SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

Filing at a Glance

Company: Zurich American Insurance Company

Product Name: Individual Accident - Additional Riders	SERFF Tr Num: ZURC-128034040	State: Arkansas
TOI: H03I Individual Health - Accidental Death & Dismemberment	SERFF Status: Closed-Approved	State Tr Num:
Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment	Co Tr Num: CW AH 34008	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Donna Lambert
	Author: Patricia Chudik	Disposition Date: 01/31/2012
	Date Submitted: 01/27/2012	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date: 03/01/2012

State Filing Description:

General Information

Project Name: CW AH 34008 - Individual Accident - Additional Riders	Status of Filing in Domicile: Pending
Project Number: CW AH 34008	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/31/2012
	State Status Changed: 01/31/2012
Deemer Date:	Created By: Patricia Chudik
Submitted By: Patricia Chudik	Corresponding Filing Tracking Number:

Filing Description:

Attached for your review are new forms use with the Individual Accident Insurance product, previously approved by your Department in state tracking number 44259, effective February 10, 2010.

The Individual Accident Policy and these riders may be marketed through brokers, consultants, third party administrators, financial institutions and sales employees.

These riders are new and are not intended to replace any other forms currently in use, except for the Administrative Change Endorsement, form U-IMC-104-B which replaces the previously filed and approved “A” version of the form.

SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

The Individual Accident Insurance product provides specified benefits for an accidental injury or death. Additional benefits are offered by way of riders. The forms are being filed concurrently in our domiciliary state of New York.

Company and Contact

Filing Contact Information

Patricia Chudik, Product Analyst	pat.chudik@zurichna.com
1400 American Lane	847-605-7714 [Phone]
Schaumburg, IL 60196-1056	847-605-7768 [FAX]

Filing Company Information

Zurich American Insurance Company	CoCode: 16535	State of Domicile: New York
1400 American Lane	Group Code: 212	Company Type:
Schaumburg, IL 60102	Group Name:	State ID Number:
(847) 605-6000 ext. [Phone]	FEIN Number: 36-4233459	

Filing Fees

Fee Required?	Yes
Fee Amount:	$1,050.00
Retaliatory?	No
Fee Explanation:	$50 per form (20) + $50 for rates
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	$1,050.00	01/27/2012	55870425

SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/31/2012	01/31/2012

SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

Disposition

Disposition Date: 01/31/2012
Implementation Date: 03/01/2012
Status: Approved
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Zurich American Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Statement of variables, explanatory memorandum, and redlined copy of U-IMC-104-A to B	Approved	Yes
Form	Administrative Change Endorsement	Approved	Yes
Form	Additional Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children Benefit	Approved	Yes
Form	After School Care Benefit	Approved	Yes
Form	Inflation Benefit	Approved	Yes
Form	HIV Occupational Accident Benefit	Approved	Yes
Form	[Permanent] [Temporary] Total Disability Benefit	Approved	Yes
Form	Critical Burn Benefit	Approved	Yes
Form	Continuation of Insurance Benefit	Approved	Yes
Form	Day Care Benefit	Approved	Yes
Form	Hearing Aid or Prosthetic Appliance Benefit	Approved	Yes
Form	Emergency [Transportation] [and] [Treatment] [and] Hospital Cash Benefit	Approved	Yes
Form	Traumatic Brain Injury Benefit	Approved	Yes
Form	Home Alteration and Vehicle Modification Benefit	Approved	Yes
Form	Natural Disaster Benefit	Approved	Yes
Form	[Occupational] [or] [Voluntary Activity] Hepatitis Benefit	Approved	Yes
Form	Recuperation Benefit	Approved	Yes
Form	Student [Tuition] [and] [Expense] Reimbursement Benefit	Approved	Yes
Form	Accelerated Payment Benefit	Approved	Yes
Form	Accident Medical Expense - Indemnity Benefit	Approved	Yes

SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

Form	Complications of Pregnancy Benefit	Approved	Yes
Rate	Exhibit I Rating Structure	Approved	Yes

SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

Form Schedule

Lead Form Number: U-IMC-100

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/31/2012	U-IMC-104-B CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Administrative Change Endorsement	Revised	Replaced Form #: U-IMC-104-A CW (08/09) Previous Filing #: 44259	49.000	U-IMC-104-B CW Administrative Change Endorsement.pdf
Approved 01/31/2012	U-IMC-109-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Additional Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children Benefit	Initial		46.000	U-IMC-109-A CW Add AX[Dismemeberment].pdf
Approved 01/31/2012	U-IMC-123-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	After School Care Benefit	Initial		49.000	U-IMC-123-A CW After School Care Benefit.pdf
Approved 01/31/2012	U-IMC-124-A CW (09/11)	Policy/Contract/Fraternal	Inflation Benefit	Initial		42.000	U-IMC-124-A CW Inflation Benefit.pdf

		Certificate: Amendment, Insert Page, Endorsement or Rider					
Approved 01/31/2012	U-IMC-131-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	HIV Occupational Accident Benefit	Initial		46.000	U-IMC-131-A CW HIV Occ Benefit.pdf
Approved 01/31/2012	U-IMC-139-A AR (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	[Permanent] [Temporary] Total Disability Benefit	Initial		37.000	U-IMC-139-A AR Permanent-Temporary Total Disability Benefit.pdf
Approved 01/31/2012	U-IMC-141-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Critical Burn Benefit	Initial		54.000	U-IMC-141-A CW Critical Burn Benefit.pdf
Approved 01/31/2012	U-IMC-147-A CW (09/11)	Policy/Contract/Fraternal Certificate:	Continuation of Insurance Benefit	Initial		60.000	U-IMC-147-A CW Continuation of Ins.

		Amendment, Insert Page, Endorsement or Rider					Benefit.pdf
Approved 01/31/2012	U-IMC-148-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Day Care Benefit	Initial		54.000	U-IMC-148-A CW Day Care Benefit.pdf
Approved 01/31/2012	U-IMC-149-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Hearing Aid or Prosthetic Appliance Benefit	Initial		52.000	U-IMC-149-A CW Hearing Aid or Prosthetic Appliance Benefit.pdf
Approved 01/31/2012	U-IMC-153-A AR (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Emergency [Transportation] [and] [Treatment] [and] Hospital Cash Benefit	Initial		37.000	U-IMC-153-A AR Emergency Transport and Treatment.pdf
Approved 01/31/2012	U-IMC-161-A AR (09/11)	Policy/Contract/Fraternal Certificate: Amendmen	Traumatic Brain Injury Benefit	Initial		47.000	U-IMC-161-A AR Traumatic Brain Injury Benefit.pdf

		t, Insert Page, Endorsement or Rider					
Approved 01/31/2012	U-IMC-171-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Home Alteration and Vehicle Modification Benefit	Initial		42.000	U-IMC-171-A CW Home & Vehicle Alteration Benefit.pdf
Approved 01/31/2012	U-IMC-172-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Natural Disaster Benefit	Initial		57.000	U-IMC-172-A CW Natural Disaster Benefit.pdf
Approved 01/31/2012	U-IMC-173-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	[Occupational] [or] [Voluntary Activity] Hepatitis Benefit	Initial		35.000	U-IMC-173-A CW Occ-Vol Hepatitis Benefit.pdf
Approved 01/31/2012	U-IMC-174-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert	Recuperation Benefit	Initial		56.000	U-IMC-174-A CW Recuperation Benefit.pdf

		Page, Endorsement or Rider					
Approved 01/31/2012	U-IMC-175-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Student [Tuition] [and] [Expense] Reimbursement Benefit	Initial		38.000	U-IMC-175-A CW Tuition Reimbursement.pdf
Approved 01/31/2012	U-IMC-176-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Accelerated Payment Benefit	Initial		35.000	U-IMC-176-A CW Accelerated Payment Benefit.pdf
Approved 01/31/2012	U-IMC-177-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Accident Medical Expense - Indemnity Benefit	Initial		47.000	U-IMC-177-A CW AME Indemnity Benefit.pdf
Approved 01/31/2012	U-IMC-178-A AR (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page,	Complications of Pregnancy Benefit	Initial		36.000	U-IMC-178-A AR Complication of Preg.Benefit.pdf

SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

Endorseme
nt or Rider

Administrative Change Endorsement

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

[This endorsement will be used to make the following types of administrative changes to the **Policy** at **Your** request:

1. Policyholder's Name or Address;
2. Addition or deletion of Covered Dependent(s);
3. Addition or deletion of Coverage(s);
4. Increase or decrease in Coverage Amount(s);
5. Addition or deletion of Benefit Riders;
6. Increase or decrease in Benefit Amount(s); or
7. Renewal of the Policy.]

Except for the above, this endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy No. _____

Additional Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If **You** select a **Plan** covering **Your** eligible **Dependent Child(ren),** and a covered **Dependent Child** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage, **We** will pay [the **Covered Person**][**You**] an additional benefit which will be equal to the benefit amount provided by the Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

After School Care Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person** selects] [**You** select] [a **Plan** covering [**Dependents**][**Dependent Child(ren)**] and [the **Covered Person**][**You**] or [his or her][**Your**] **Spouse** [**/Domestic Partner**]] suffers a **Covered Injury** resulting in a **Covered Loss** which is payable under the [Accidental Death [and Accidental Dismemberment] Coverage, **We** will reimburse the charges actually incurred by [the **Covered Person**][**You**] for the after school care for each **Dependent Child**, who is [ten (10)] years old or less, up to the amount shown on the Schedule.

The after school care provider may not be **Related** to [the **Covered Person**][**You**] and proof acceptable to **Us** must be provided with the Proof of Covered Loss to establish eligibility for this benefit.

[If [the **Covered Person**][**You**] and [his or her][**Your**] **Spouse** [/**Domestic Partner**] both die as a result of the same **Covered Injury**, and **We** pay a[n] [Accidental Death] **Principal Sum** amount on both **Covered Persons**, only the **Policyholder's Principal Sum** will be used to calculate the amount applicable under this benefit.]

This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child(ren)** [is][are] under age [ten (10)] at the time of each payment.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Inflation Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person** sustains] [**You** sustain] a **Covered Injury** that results in a **Covered Loss** payable under the [Accidental Death [and Accidental Dismemberment]] Coverage, the Inflation Benefit will provide an inflation adjustment to the **Principal Sum**.

The Inflation Benefit is [the **Covered Person's**] [**Your**] amount of **Principal Sum**, at the time of claim, multiplied by the product of:

1. the Inflation Benefit Percentage as shown on the Schedule; and
2. one (1) credited year for every two (2) years of continuous coverage under the **Policy** prior to the **Covered Loss**; to a maximum of [ten (10)] multiplied by the injured **Covered Person's** amount of original **Principal Sum**. [(Principal Sum) x (Benefit Percentage x Years of Credited Coverage) = Inflation Benefit amount.]

[If [a **Covered Person**] [**You**] increases the **Principal Sum**, **We** will apply the Inflation Benefit separately to each additional increase under the **Policy**. Likewise, if [a **Covered Person** decreases] [**You** decrease] the **Principal Sum**, **We** will correspondingly reduce any Inflation Benefit that was previously increased.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

HIV Occupational Accident Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [the **Covered Person** suffers][**You** suffer] a **Covered Injury** resulting in a **Covered Loss** while performing his or her job related duties, which causes [the **Covered Person**][**You**] to acquire and test positive within [three hundred sixty-five (365)] days of such **Covered Accident** for Human Immunodeficiency Virus (HIV) and/or AIDS and related complex (ARC), **We** will pay an HIV Occupational Accident Benefit. Such HIV Occupational Accident Benefit will be equal to the amount shown on the Schedule. The HIV Occupational Accident Benefit will be paid in [twenty-four (24)] equal monthly installments.

In order to receive the HIV Occupational Accident Benefit, [the **Covered Person**][**You**] must:

1. submit a workers' compensation injury report to his or her employer within seventy-two (72) hours of the **Covered Accident**. If [the **Covered Person's**][**Your**] employer does not maintain workers' compensation insurance, [the **Covered Person**][**You**] must complete a Proof of Covered Loss form that **We** will provide. The completed Proof of Covered Loss form must be approved by [the **Covered Person's**][**Your**] employer within seventy-two (72) hours of the **Covered Accident** and must be submitted to **Us** within five (5) days of the **Covered Accident**; and
2. submit to a blood test for HIV and/or AIDS and/or related complex (ARC) within seventy-two (72) hours of the **Covered Accident**, which is administered by a **Physician**. The blood test results must be sent directly to **Us**.

If the initial test is negative, and [the **Covered Person**][**You**] subsequently test(s) positive for HIV, AIDS or ARC within [three hundred sixty-five (365)] days of the **Covered Accident**, **We** will begin monthly payments on the first day of the month following receipt of the report indicating positive test results.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

[Permanent][Temporary] Total Disability Benefit

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person**][**You**] suffer[s] a **Covered Injury** resulting in a **Covered Loss** that renders [the **Covered Person**][**You**] [Permanently][Temporarily] **Totally Disabled**, **We** will pay a [Permanent][Temporary] Total Disability Benefit provided that [the **Covered Person** becomes] [**You** become] [Permanently][Temporarily] **Totally Disabled** within [three hundred-sixty (365)] days of the **Covered Injury**; and the [Permanent] [Temporary] **Total Disability** continues for [twelve (12)] consecutive months.

The [monthly] [lump sum] amount payable under this benefit will be equal to the amount shown on the Schedule. [The payments under this benefit will cease at the earliest of the following times:

1. **We** make [sixty (60)] payments under this benefit;
2. [The **Covered Person** is][**You** are] no longer [Permanently] [Temporarily] **Totally Disabled**; or
3. [**You**] [The **Covered Person**] die[s].

Payments will begin on the thirty-first (31st) consecutive day of **Total Disability** and will continue for as long as [the **Covered Person** is] [**You** are] [Permanently] [Temporarily] **Totally Disabled**, but will not exceed the **Benefit Period** of [sixty (60)] months.] As a condition of coverage, **We** must receive proof of continuing **Total Disability** on a regular basis.]

Successive periods of **Total Disability** arising out of the same **Covered Injury** will be considered one **Total Disability** if they are separated by a period of less than [six (6)] months.

For purposes of this rider only, the following additional definitions apply:

Continuous Care means monthly monitoring and/or evaluation of the disabling condition by a **Physician.**

[**Benefit Period** means the time period that benefits are payable under this benefit subject to any other restrictions or limitations in the **Policy**.]

Total Disability (Totally Disabled) means disability that:

1. prevents [a **Covered Person**] [**You**] from performing the material and substantial duties of any occupation for which [the **Covered Person** is] [**You** are] qualified by reason of education, training, or experience [or if for a **Covered Person** whom is not employed means that the person is unable to engage any of the usual activities of a person of like age and sex whose health is comparable to that of [the **Covered Person**][**You**]] immediately prior to the **Covered Accident**; and
2. requires the **Continuous Care** and treatment of a **Physician**.

If [the **Covered Person** does][**You** do] not adhere to the treatment plan the **Physician** prescribes relating to [the **Covered Person's**][**Your**]disabling condition, [the **Covered Person**] [**You**] shall not qualify for the [Permanent] [Temporary] Total Disability Benefit. [The **Covered Person**] [**You**] shall not qualify for **Total Disability** if [the **Covered Person**] [**You**] engage(s) in any activity, such as employment, that results in earned income.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____.

Critical Burn Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** that is a **Critical Burn** resulting in a **Covered Loss** as a result of a **Covered Accident**, **We** will pay a benefit as shown on the Schedule, provided:

1. [The **Covered Person** receives] [**You** receive] [second degree or higher] burns over at least [twenty-five (25)%] of his or her body[; and][.]
2. [within [three hundred-sixty-five (365)] days of the **Covered Accident**, [the **Covered Person** has][**You** have] undergone reconstructive surgery to treat the burned areas of the body.]

For purposes of this rider only, **Critical Burn** means cosmetic disfigurement of the surface of a body area due to a **Covered Injury** [that is a full-thickness or third-degree burn,] as determined by a **Physician**. [(A full- thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Continuation of Insurance Benefit

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If **You** [select a **Plan** covering **Your** [**Spouse**[**/Domestic Partner**]] [and] [**Dependent Child(ren)**] and **You** suffer a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death Coverage, provided there are no premium payments in arrears, all coverages under this **Policy** which were in force on the date of the loss will continue with respect to **Your** eligible **Dependents** for [three hundred sixty-five (365) days] after the date of loss with no additional premium payments.

For purposes of this rider only, insurance for eligible **Dependents** terminates on the earliest of:

1. [three hundred sixty-five (365) days] after the date of **Covered Loss**;
2. the first premium due date after the **Dependent** no longer qualifies as a **Covered Person**;
3. [for the covered **Spouse**[**/Domestic Partner**], the date the covered **Spouse**[**/Domestic Partner**] reaches age [seventy (70)].]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Day Care Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If **You** [select a **Plan** covering **Your Dependents** and **Your** covered **Spouse** [**/Domestic Partner**]] suffers a **Covered Injury** resulting in a **Covered Loss,** which is payable under the Accidental Death Coverage, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each covered **Dependent Child** if:

1. on the date of the **Covered Accident**, the covered **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and
2. the covered **Dependent Child** is under age [thirteen (13)].

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the child care;
2. [three (3)%] of the **Principal Sum** of the [**Covered Person][Policyholder]** who suffered the **Covered Loss**; or
3. [$3,000].

If both **You** and **Your** covered **Spouse** [**/Domestic Partner**] suffer a simultaneous **Covered Loss** which is payable under the Accidental Death Coverage, the Day Care Benefit will be based on **Your Principal Sum**.

The Day Care Benefit will be paid annually for [four (4)] consecutive years if:

1. the covered **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the covered **Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

For purposes of this rider only, an **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a **Hospital**; the **Dependent Child**'s home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

Hospital means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides 24-hour nursing service by or under the supervision of graduate registered nurses (R.N.).

Hospital does not mean any institution or part thereof that is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism, or substance abuse.

However, a place for the treatment of mental illness, alcoholism, or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the above requirements; and
2. listed in the American Hospital Association Guide as a general **Hospital**.

[The maximum amount payable under this benefit is [$4,000].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Hearing Aid or Prosthetic Appliance Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Coverage, **We** will pay an additional benefit provided:

1. [the **Covered Person** is][**You** are] required to use a Hearing Aid or **Prosthetic Appliance**;
2. the **Covered Injury** that caused the payment of the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Coverage is the same **Covered Injury** that requires [the **Covered Person**] [**You**] to use the Hearing Aid or **Prosthetic Appliance**; and
3. the Hearing Aid or **Prosthetic Appliance** was required within [three hundred sixty-five (365)] days of the **Covered Injury**.

The amount **We** will pay will be equal to the one time cost of the Hearing Aid or **Prosthetic Appliance** actually paid by [the **Covered Person**][**You**].

This benefit will not be paid unless:

1. the Hearing Aid or **Prosthetic Appliance** was prescribed by a **Physician** who is not [the **Covered Person's**] [**Your**] **Spouse**[/**Domestic Partner**]; and
2. presentation of proof of payment is provided to **Us**.

For purposes of this rider only, **Prosthetic Appliance** means a replacement or artificial substitution for a missing body limb or eye. This does not include a dental prosthetic device such as dentures or crowns.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [ten (10)%] of the [**Principal Sum** of the **Covered Person**][**Your Principal Sum**] or [$10,000].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Emergency [Transportation] [and] [Treatment] [and] Hospital Cash Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

This policy IS NOT A MEDICARE SUPPLEMENT POLICY.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

[EMERGENCY TRANSPORTATION BENEFIT.

If [a **Covered Person** suffers][**You** suffer] a **Covered Injury** that requires **Emergency Treatment** within [12, 24, 48] hours of the date of the **Covered Accident** that caused the **Covered Injury** and it is determined that it is **Medically Necessary** that][the **Covered Person**][**You**] be transported to a **Hospital** or a **Satellite Emergency Center** by **Ambulance**, the Company will pay 100% of the Emergency Transportation Maximum Amount shown in the Schedule. Only one Emergency Transportation Benefit is payable for any one **Covered Accident** [per **Covered Person**][to **You**]. [The maximum number of Emergency Transportation Benefits payable per calendar year [per **Covered Person**][to **You**] regardless of the number of **Covered Accidents** incurred, is shown in the Schedule.]]

[EMERGENCY TREATMENT BENEFIT.

If [**a Covered Person** suffers][**You** suffer] a **Covered Injury** that, within [24, 48, 72] hours of the date of the **Covered Accident** that caused the **Covered Injury,** requires [the **Covered Person**][**You**] to receive **Medically Necessary Emergency Treatment** in a **Hospital** emergency room or a **Satellite Emergency Center**, the Company will pay 100% [of the applicable] Emergency Treatment Benefit amount shown in the Schedule. Only one Emergency Treatment Benefit[, the largest,] is payable for any one **Covered Accident** [per **Covered Person**] [to **You**]. [The maximum number of Emergency Treatment Benefits payable per calendar year [per **Covered Person**] [to **You**] regardless of the number of **Covered Accidents** incurred, is shown in the Schedule.]]

[If [a **Covered Person** incurs][**You** incur] expenses for both Emergency Transportation and **Emergency Treatment** due to the same **Covered Accident**, only one amount, the highest, will be paid.] [A maximum of [2] Emergency Transportation Benefits or **Emergency Treatment** Benefits are payable [per **Covered Person**] [to **You**] per calendar year regardless of the number of **Covered Accidents** incurred in that same calendar year.]

EMERGENCY HOSPITAL CASH

If [a **Covered Person** is][**You** are] **Hospital Confined** due to **Covered Injury**, **We** will pay a daily allowance according to the actual days in **Hospital** up to the maximum benefit of [thirty (30)] days. [**We** will not pay any claim for the first three (3) calendar days of each emergency hospital cash within the United States.]

For purposes of this rider only, the following additional definitions apply:

[**Ambulance** means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded. **Ambulance** does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]

Emergency Treatment means treatment for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Hospital means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides 24-hour nursing service by or under the supervision of graduate registered nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism, or substance abuse.

However, a place for the treatment of mental illness, alcoholism, or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the above requirements; and
2. listed in the American Hospital Association Guide as a general **Hospital**.

Hospital Confinement (Hospital Confined) means admission to a **Hospital** as an inpatient for at least [twenty-four (24)] consecutive hours by a **Physician** for a **Covered Injury**. A **Hospital** stay that does not result in charges to [the **Covered Person**][**You**] is not a **Hospital Confinement** under this rider unless there is no charge because the **Hospital** is a United States government facility.

Medically Necessary means an [**Emergency Treatment**] [or] [Emergency Transportation] is:

1. essential for the diagnosis, treatment and care of the Injury;
2. meets generally accepted standards of medical practice; [or]
3. is ordered by a **Physician** and performed under the **Physician's** care, supervision or order[; or
4. [with regard to Emergency Transportation, is subsequently authorized by a **Physician** as appropriate due to the nature of the **Covered Injury**].

Satellite Emergency Center means a licensed facility providing outpatient care under the direction of a **Physician** on a twenty-four (24) hour basis. Available services must include:

1. diagnostic care, including laboratory services and diagnostic x-rays; and
2. treatment or medical care, including availability of the means for stabilization of emergency medical conditions. A Satellite Emergency Center does not include a **Hospital** or an office maintained by a **Physician** for the practice of medicine or dentistry).

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Traumatic Brain Injury Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** that results in a **Traumatic Brain Injury** within [ninety (90)] days of the date of the **Covered Accident** which:

1. requires [that a **Covered Person**][**You** to] be **Hospitalized** for at least [seven (7)] days during the first [ninety (90)] days following the **Covered Accident**; and
2. continues for [nine (9)] consecutive months,

We will pay a **Traumatic Brain Injury** Benefit.

This benefit will be paid after **We** receive Proof of Covered Loss, in accordance with the Proof of Covered Loss section of the **Policy**.

The **Traumatic Brain Injury** Benefit is equal to [the **Principal Sum** of the **Covered Person** that sustained the **Covered Injury**][**Your Principal Sum** provided that **You** sustained the **Covered Injury**].

[**We** will not pay this benefit if a benefit is payable to [a **Covered Person**] [**You**] for Loss of Life under the Accidental Death [and Accidental Dismemberment] Coverage].

For purposes of this rider only, the following additional definitions apply:

Hospital or **Hospitalized** means admission to an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides 24-hour nursing service by or under the supervision of graduate registered nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism or substance abuse.

However, a place for the treatment of mental illness, alcoholism or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the above requirements; and
2. listed in the American Hospital Association Guide as a general **Hospital**.

Traumatic Brain Injury means physical damage to the brain which is certified by a **Physician** to be:

1. permanent, complete and irreversible; and
2. prevents the injured person from performing all the substantial and material functions and activities of a person of like age and gender in good health.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Home Alteration and Vehicle Modification Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Dismemberment [and Covered Loss of Use][and Plegia] coverage, **We** will pay an additional benefit for home alterations and/or vehicle modifications, provided:

1. [the **Covered Person** is] [**You** are] required to use a wheelchair to be ambulatory on a permanent basis; and
2. the **Covered Injury** that caused the payment of the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Coverage is the same **Covered Injury** that requires [the **Covered Person**] [**You**] to use the wheelchair.

The amount **We** will pay will be equal to the one time cost of:

1. home alterations to [the **Covered Person's**] [**Your**] primary residence to make it wheelchair accessible and habitable; and
2. vehicle modifications necessary to [the **Covered Person's**][**Your**] primary use motor vehicle to make the vehicle accessible or driver-side modification for wheelchair use.

For purposes of this rider only, benefits will not be payable unless:

1. home alterations and/or vehicle modifications are made by a person or persons experienced in such home alterations and/or vehicle modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. proof of payment for the home alterations and vehicle modifications is provided to **Us**.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [ten (10)%] of [the **Principal Sum** of the **Covered Person** that sustained the **Covered Injury**][**Your Principal Sum**] or [$10,000].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Natural Disaster Benefit

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person**] [**You**] suffer[s] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death [or Accidental Dismemberment] [and Covered Loss of Use] [and Plegia] Coverage, **We** will pay a benefit equal to the lesser of [ten (10)%] of the [**Covered Person's**] [**Your**] **Principal Sum** or [$10,000], provided [the **Covered Person**] [**You**] suffer[s] the **Covered Injury** as a direct result of a **Natural Disaster**.

For purposes of this rider only, **Natural Disaster** means a weather event such as a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event, that arises from natural causes without direct human involvement and results in severe and widespread damage.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

[Occupational] [or] [Voluntary Activity] Hepatitis Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person**][**You**] test[s] positive for **Hepatitis** within [three hundred sixty-five (365)] days of the date of an [**Occupational Incident**] [or] [**Volunteer Activity**], **We** will pay the benefit amount to [the **Covered Person** shown in the Schedule][**You**]. The benefit is payable if, within seventy-two (72) hours of the [**Occupational Incident**] [or] [**Volunteer Activities**], the [**Covered Person**][**You**]:

1. report[s] the [**Occupational Incident**] [or] [**Volunteer Activity**] to **Us** [and the **Policyholder**] in writing; and
2. undergoes a Food and Drug Administration (FDA) approved preliminary screening test for **Hepatitis** which indicates negativity with respect to the presence of any antibodies or antigens to such disease.

We must receive written notification of the test results from the laboratory which performed the test as soon as reasonably possible.

The benefit is payable monthly, starting on the last day of the month which immediately follows the month the [**Covered Person**][**You**] tests positive for **Hepatitis**, for [one hundred twenty-seven (127) consecutive months] or until:

1. the date the [**Covered Person**] [**You**] dies; or
2. the date the [**Covered Person**] [**You**] recovers from **Hepatitis**, whichever occurs first.

If the [**Covered Person**] [**You**] tests positive for **Hepatitis** as a result of the same [**Occupational Incident**] [or] [**Volunteer Activity**], only one benefit amount, the largest, will be paid. **We** will not pay for any expenses incurred for testing.

For purposes of this rider only, the following additional definitions apply:

Hepatitis means inflammation of the liver caused by a virus or a toxin. Hepatitis includes Hepatitis [A], B, C, D and E.

[**Occupational Incident(s),** means a **Covered Accident** resulting in exposure to **Hepatitis** which occurs while the [**Covered Person**] [**You**] is performing occupational services. The exposure must be either:

1. cutaneous through abraded skin;
2. percutaneous; or
3. mucocutaneous.]

[**Volunteer Activity** (**Volunteer Activities**) means a **Covered Accident** resulting in exposure to **Hepatitis** which occurs while the [**Covered Person** is] [**You** are] performing services as a volunteer. The exposure must be either:

1. cutaneous through abraded skin;
2. percutaneous; or
3. mucocutaneous.]

This rider only provides benefits for [**Occupational Incidents**] [or] [**Volunteer Activity**] as defined above.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Recuperation Benefit

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person**] [**You**] suffer[s] a **Covered Injury** resulting in a **Covered Loss** and [the **Covered Person** is][**You** are] eligible to receive benefits payable under the [In-Hospital Indemnity Benefit] of the **Policy**, **We** will pay an additional Recuperation Benefit.

The Recuperation Benefit is equal to the amount shown on the Schedule and will be paid for the same [period of time as the][number of days as was actually paid for the] [In-Hospital Indemnity Benefit].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Student [Tuition] [and] [Expense] Reimbursement Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**.

[Student Loan Reimbursement
If [a **Covered Person** is][**You** are] a **Tuition Payor** and suffer[s] a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Coverage, **We** will pay [the **Covered Person's**][**Your**] outstanding loan balance incurred **Student Tuition** as of date of the **Covered Loss** and owed to a financial institution or federal government for **Academic Studies.** The most **We** will pay is up to the benefit amount shown on the Schedule.]

[Tuition Reimbursement
If [a **Covered Person** is][**You** are] enrolled in **Academic Studies** and suffer[s] a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Coverage and which prevents [the injured **Covered Person**][**You**] from continuing to participate in **Academic Studies**, **We** will pay a **Tuition Expense** benefit as shown on the Schedule.]

[Student Tuition and Tuition Expenses
If [a **Covered Person** that is][**You** are] a **Tuition Payor** and suffer[s] a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Coverage and there is an obligation to pay **Student Tuition** [to the **Policyholder**] on behalf of [the **Covered Person**][**You**], **We** will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The benefit amount will increase annually by the lesser of the actual **Student Tuition** and **Tuition Expense**, or [ten (10%)].]

[Student Expenses
If [a **Covered Person** is][**You** are] a **Tuition Payor** and suffer(s) a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Coverage and prevents the **Tuition Payor** from continuing to pay the **Student Expenses** incurred by the **Covered Person** for **Academic Studies**, **We** will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The benefit amount will increase annually by the lesser of the actual **Student Expenses** or [ten (10%)].]

For purposes of this rider only, the following additional conditions apply:

Eligibility of a **Covered Person**. At the time of the **Covered Loss**, the **Covered Person** must be enrolled as a full-time student or have already been accepted by an accredited university, college, charter school, private school, magnet school, parochial school, or other such similar school where a **Tuition Expense** is incurred for **Academic Studies**.

Payment Of Claims. Unless otherwise requested by **You**, the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Coverage will be paid directly to the [**Covered Person**] [or beneficiary] [or **Policyholder**] up to the total amount of actual [**Tuition Expense**] [and] [**Student Expenses**] due from the **Tuition Payor**. Any payment made in good faith will release **Us** from any liability to the extent of the payment.

For the purposes of this rider only, the following additional definitions apply:

Academic Studies means the full-time attendance at an educational institution or school for the purpose of advancing education and for which the **Tuition Payor** incurred **Student Tuition** [and room and board (if supplied by the university, college or trade school)] to attend.

[**Covered Person** means any person who has insurance under the terms of this **Policy**. It includes **You** [,and **Your Spouse**[**/Domestic Partner**] and/or **Dependent Child(ren)** if a **Plan** covering the **Spouse** [**/Domestic Partner**] and/or **Dependent Child(ren)** is selected. **Covered Person** also includes the **Spouse**[**/Domestic Partner**] and/or **Dependent Child(ren)** designated by **You** as enrolled in **Academic Studies** regardless of the **Plan** chosen by **You**.]

Student Expense means those fees and expenses incurred or that would have been incurred by the **Tuition Payor** on behalf of a **Covered Person** for housing, transportation, and meal plan as charged by a school.

Student Tuition means the amount of money paid or to be paid, including administrative fees, by the **Tuition Payor** to an educational institution or school , including grammar schools, high schools, trade schools, university, or college. **Student Tuition** does not include housing or other living expenses.

Tuition Expenses means the actual unreimbursed amount of **School Tuition** incurred or that would have been incurred by the **Tuition Payor** on behalf of a **Covered Person** to attend the school for **Academic Studies** including expenses incurred for learning material such as books.

Tuition Payor means the person(s) or individual(s) named or designated in the Application or Enrollment form as the person(s) or individual(s) that is/are financially responsible for paying the **Tuition Expenses** for the **Covered Person** that is a full-time student.

[For purposes of this rider only, the following additional exclusions apply. Coverage does not apply to:

1. [Expenses previously reimbursed to the **Tuition Payor** or **Covered Person** through any employment tuition reimbursement program;]
2. [Academic Scholarships provided to the **Covered Person**.]
3. [Athletic Scholarships provided to the **Covered Person**.]
4. [Student loans made to or on behalf of the **Tuition Payor** or the **Covered Person**.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Accelerated Payment Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

In the event that [a **Covered Person** is][**You** are] **Terminally Injured**, [the **Covered Person**][**You**] may be eligible to receive an Accelerated Payment Benefit. **We** will pay the applicable Accelerated Payment Benefit amount as shown below, provided the **Terminally Injured Covered Person**:

1. is covered under the **Policy**;
2. is under age [60-70]; and
3. provides Proof of Loss to **Us** of such **Terminal Injury**.

[The **Covered Person**][**You**] must request in writing that a portion of the **Terminally Injured Covered Person's** amount of Accidental Death Coverage be paid as an Accelerated Benefit. However, if [the **Covered Person** is][**You** are] incompetent or unable to provide a request for the Accelerated Benefit, [the **Covered Person's**][**Your**] legal guardian may submit the request. The amount of Accidental Death Coverage payable upon the **Terminally Injured Covered Person's** death will be reduced by any Accelerated Benefit amount paid under this benefit.

[The **Covered Person**][**You**] may request a minimum Accelerated Benefit amount of [$3,000, and a maximum of $100,000]. However, in no event will the Accelerated Benefit amount exceed [thirty (30)%] of [the **Covered Person**][**Your**] **Principal Sum** of Accidental Death Coverage. [This option may be exercised only once for [each **Covered Person**][**You**].] The Accelerated Benefit payment will be made to [the **Covered Person**][**You**] now instead of [the **Covered Person's**][**Your**] beneficiary upon death.

[For example, if [the **Covered Person** is][**You** are] covered for an Accidental Death Coverage amount under the **Policy** of [$100,000] and **Terminally Injured**, [the **Covered Person**][**You**] can request any portion of the amount of Accidental Death Coverage from $3,000 to $30,000 to be paid now instead of to [the **Covered Person's**][**Your**] beneficiary upon death. However, if [the **Covered Person** decides][**You** decide] to request only [$3,000] now, [the **Covered Person**][**You**] cannot request the additional [$27,000] in the future]. Any benefits received under this rider may be taxable. [The **Covered Person**][**You**] should consult a personal tax advisor for further information.

[The **Covered Person**][**You**] will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit. If [the **Covered Person** has][**You** have] executed an assignment of rights and interest with respect to [the **Covered Person's**][**Your**] Accidental Death Coverage, in order to receive the Accelerated Benefit, **We** must receive a release from the assignee before any benefits are payable.

We reserve the right to require satisfactory proof of **Terminal Injury** on an ongoing basis. Any diagnosis submitted must be provided by a **Physician**.

If [the **Covered Person** does][**You** do] not submit Proof of Loss of **Terminal Injury**, or if [the **Covered Person** refuses][**You** refuse] to be examined by a **Physician** as **We** may require, then **We** will not pay an Accelerated Benefit. If [the **Covered Person** is][**You** are] diagnosed by a **Physician** as no longer **Terminally Injured** and:

1. a **Covered Person**, coverage will remain in force, provided premium is paid;
2. not in an Eligible Class, but [the **Covered Person** continues][**You** continue] to meet the definition of **Disabled,** coverage will remain in force, subject to the Change or Waiver condition within the **Policy**; and
3. Accelerated Benefit amounts previously paid to [the **Covered Person**][**You**] must be returned.

In any event, the amount of Accidental Death Coverage will be reduced by the Accelerated Benefit paid.

For purposes of this rider only, the following additional definitions apply:

Disabled means that due to the **Terminal Injury** the [**Covered Person** is][**You** are]:

1. unable to perform the material and substantial duties of any occupation to which [the **Covered Person**][**You** are] suited by education, training, and experience; [or
2. with respect to a **Spouse**[/**Domestic Partner**] who is unemployed, his or her ability to engage in the normal and customary activities of a person of like age and gender in good health.]

Terminal Injury or Terminally Injured means the **Covered Injury** suffered by [the **Covered Person**][**You**] which resulted in [the **Covered Person**][**You**] having a life expectancy of [nine (9)] months or less.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Accident Medical Expense - Indemnity Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person** suffers][**You** suffer] a **Covered Injury** resulting in a **Covered Loss** under this **Policy**, **We** will pay the following benefits as applicable [per **Covered Person**][to **You**] for each **Covered Accident**. The **Covered Injury** must be independent of **Sickness** or the medical or surgical treatment of **Sickness**, or of any cause other than a **Covered Accident**. A **Covered Loss** must also occur while coverage is in force.

[Emergency Room Treatment
We will pay [$500] once per [forty-eight (48)] hour period per **Covered Accident**, [per **Covered Person**][to **You**] when [that **Covered Person** receives][**You** receive] emergency room treatment for **Injuries** sustained in a **Covered Accident**. This benefit is for treatment by a **Physician** or treatment received in a **Hospital** emergency room. Treatment must be received within [forty-eight (48)] hours of the **Accident** for benefits to be payable.]

[X-Rays Related to an Accident
We will pay [$500] once per **Covered Accident** [per **Covered Person**][to **You**] when [a **Covered Person** requires][**You** require] an X-ray while receiving emergency room treatment in a **Hospital** for **Injuries** sustained in a **Covered Accident**. This benefit is not for X-rays received in a **Physician's** office. [The X-Ray Benefit is not for exams listed in the Diagnostic Testing & Exams Benefit.]]

[Emergency Room Follow Up Treatment
We will pay [$500] for one treatment per day, up to a maximum of [three (3)] treatments per **Covered Accident** for [each **Covered Person**][**You**] when [that **Covered Person** receives][**You** receive] emergency room treatment for **Injuries** sustained in a **Covered Accident** and later requires additional treatment in addition to the original emergency room treatment administered in the first [forty-eight (48)] hours following the **Covered Accident**. The subsequent treatment must begin within [thirty (30)] days of the **Covered Accident** or discharge from the **Hospital**, the **Hospital Confinement** for which must be related to the same **Covered Accident** for which the subsequent treatment is being sought. Treatments must be furnished by a **Physician** in a **Physician's** office or in a **Hospital** on an outpatient basis. This benefit is not payable for days wherein additional emergency room treatment benefits are payable.]

[Accident Hospitalization
We will pay [$500] once per period of **Hospital Confinement** or [$500] once when [a **Covered Person** is][**You are**] admitted directly to an **Intensive Care Unit** [two (2) time(s)] per calendar year [per [**Covered Person**][to **You**] when [that **Covered Person** is][**You** are] admitted for a **Hospital Confinement** of at least [eighteen (18)] hours for treatment of **Injuries** sustained in a **Covered Accident** or if [a **Covered Person** is][**You** are] admitted directly to an **Intensive Care Unit** of a **Hospital** for treatment of **Injuries** sustained in a **Covered Accident**. **Hospital Confinements** must start within [sixty (60)] days of the **Covered Accident**.]

[Specific **Principal Sum** Accidental Injuries
We will pay [$5,000] for the following **Covered Injuries**:

[1. Dislocation Benefit
Dislocation (reduced under general anesthesia)
We will pay for no more than [two (2)] **Dislocations** per **Covered Accident** [per **Covered Person**][to **You**]. Benefits are payable for each **Dislocation** for each joint but for only the first **Dislocation** of a joint.

Benefit:

Joint Area	Open Reduction	Closed Reduction
A. Hip	[$2,500]	[$500]
B. Knee	[$2,500]	[$500]

C. Shoulder	[$2,500]	[$500]
D. Collar Bone	[$2,500]	[$500]
E. Ankle or Foot	[$2,500]	[$500]
F. Lower Jaw	[$2,500]	[$500]
G. Wrist	[$2,500]	[$500]
H. Elbow	[$2,500]	[$500]
I. Toe	[$2,500]	[$500]
J. Finger	[$2,500]	[$500]

If a **Dislocation** is reduced with local anesthesia, or no anesthesia by a **Physician** or a Physician Assistant, **We** will pay [fifty (50)] percent of the amount shown for the closed **Reduction Dislocation**.]

[2. Burn Benefit
For burns arising out of a **Covered Accident** and treated by a **Physician** within [forty – eight (48)] hours after that **Covered Accident**, **We** will pay the following:

Benefit:

Body Surface Area	**2nd Degree**	**3rd Degree**
A. Less than 50 square centimeters	[$2,500]	[$5,000]
B. More than 100 but less than 150 square centimeters	[$2,500]	[$5,000]
C. More than 150 but less than 200 square centimeters	[$2,500]	[$5,000]
D. More than 200 but less than 250 square centimeters	[$2,500]	[$5,000]
E. More than 250 but less than 300 square centimeters	[$2,500]	[$5,000]
F. More than 300 square centimeters	[$2,500]	[$5,000]]

]

[3. Skin Grafts
If [a **Covered Person** receives][**You** receive] up to [five (5)] skin graft(s) for a burn from a **Covered Accident**, **We** will pay a total of [seventy-five (75)%] of the Burn Benefit amount **We** paid for the burn involved in addition to the amount paid for the Burn Benefit.]

[4. Eye Injuries
If [[a **Covered Person** sustains][**You** sustain]an **Injury** to an eye as a results of a **Covered Accident**, **We** will pay the following:

a. Surgical repair [$1,000]

b. Removal of foreign body by a **Physician** [$250].]

[5. Lacerations
If [a **Covered Person** sustains][**You** sustain] a laceration as a result of a **Covered Accident**, provided the laceration is repaired within [forty-eight (48)] hours after the **Covered Accident** and repaired under the attendance of a **Physician, We** will pay the following:

Benefit:

Laceration	**Benefit Amount**
A. Laceration(s) not requiring sutures and treated by a **Physician** (total length of all lacerations)	[$500]
B. Laceration(s) less than 5 centimeters in length (total of all lacerations)	[$500]
C. Lacerations at least 5 centimeters in length but not more than 15 centimeters in length (total of all lacerations)	[$500]
D. Lacerations over 15 centimeters in length (total of all lacerations)	[$500]]

]

[6. Fractures
We will pay for no more than [five (5)] **Fractures** per **Covered Accident**, [per **Covered Person**][to **You**]. In the event of multiple fractures (more than [three (3)]) sustained by [the same **Covered Person**][to **You**], **We** will pay for the largest **Fracture** amount. However, **We** will pay [fifty (50)] percent of the benefit amount shown for the closed **Reduction** for **Chip Fractures** and other **Fractures** not reduced by Open or Closed **Reduction**.

Benefit:

Fracture Area	Open **Reduction**	Closed **Reduction**

A. Hip	[$15,000]	[$7,500]
B. Leg	[$15,000]	[$7,500]
C. Hand (excluding fingers)	[$15,000]	[$7,500]
D. Foot (excluding heel/toes)	[$15,000]	[$7,500]
E. Wrist	[$15,000]	[$7,500]
F. Kneecap	[$15,000]	[$7,500]
G. Lower Jaw	[$15,000]	[$7,500]
H. Shoulder	[$15,000]	[$7,500]
I. Vertebrae (body of)	[$15,000]	[$7,500]
J. Pelvis (excluding coccyx)	[$15,000]	[$7,500]
K. Sternum	[$15,000]	[$7,500]
L. Upper Jaw	[$15,000]	[$7,500]
M. Upper Arm	[$15,000]	[$7,500]
N. Face (excluding nose)	[$15,000]	[$7,500]
O. Rib	[$15,000]	[$7,500]
P. Nose	[$15,000]	[$7,500]
Q. Heel	[$15,000]	[$7,500]
R. Finger	[$2,500]	[$1,000]
S. Coccyx	[$10,000]	[$7,500]
T. Toe	[$2,500]	[$1,000]
U. Vertebral Processes	[$10,000]	[$7,500]
V. Skull (i) Depressed (ii) Simple	 (i)[$10,000] (ii)[10,000]	 (i)[$7,500] (ii)[7,500]

]

[7. Concussion:

If [a **Covered Person** sustains][**You** sustain] a concussion as a result of a **Covered Accident**, **We** will pay [$1,000] for each concussion for [each **Covered Person**][**You**].]

[8. Emergency Dental Procedure:

If [a **Covered Person** sustains][**You** sustain] a **Covered Injury** as a result of a **Covered Accident** requiring emergency dental work, **We** will pay the following benefits:

a. Broken tooth repaired with crown [$750]

b. Broken tooth resulting in extraction [$750]

Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. **We** will pay for no more than [two (2)] Emergency Dental Procedure benefit(s) per **Covered Accident**, [per **Covered Person**][to **You**].]

[9. Specified Surgical Procedures Arising from a Covered Accident:

If [a **Covered Person** sustains][**You** sustain] a **Covered Injury** as a result of a **Covered Accident** and one of the specified surgical procedures is required, such surgical procedure must be performed within [one (1)] year(s) of the **Covered Accident**. [Two (2) or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, **We** will pay for the most expensive procedure.

Benefit:

Surgical Procedure	Benefit Amount
A. Arthroscopy without surgical repair	[$5,000]
B. Open abdominal (including exploratory laparotomy)	[$5,000]
C. Cranial	[$5,000]
D. Hernia	[$5,000]
E. Thoracic surgery	[$5,000]
F. Repair of: i. Tendons and/or ligaments ii. Torn rotator cuffs iii. Ruptured discs iv. Torn knee cartilages	[$5,000]]

]

[10. Non-Specified Surgical Procedures Arising from a Covered Accident:
If [a **Covered Person** sustains][**You** sustain] a **Covered Injury** as a result of a **Covered Accident** and a non-specified surgical procedure is required, such surgical procedure must be performed within [one (1)] year of **Covered Accident**. [Two (2) or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, **We** will pay for the most expensive procedure. **We** will pay for the following:

a. Miscellaneous surgery with general anesthesia [$2,500]

b. Other miscellaneous surgery with conscious sedation [$2,500]]

[Diagnostic Testing & Exams Benefit
We will pay [$2,500] [five (5) time(s)] per calendar year, [per **Covered Person**][for **You**] when [a **Covered Person** requires][**You** require] one of the following exams for **Injuries** sustained in **Covered Accident** and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a **Hospital** or a **Physician's** office. [Exams listed in the Diagnostic Testing & Exams Benefit are not covered under the X-Ray Related to an **Accident** Benefit.]]

[Pain Management
We will pay [$2,500] no more than [five (5) time(s)] per **Covered Accident**, [per **Covered Person**][for **You**] when [a [**Covered Person** is][**You** are] prescribed, receives, and incurs a charge for an epidural or other similar treatment administered for pain management in a **Hospital** or a **Physician's** office for **Injuries** sustained in a **Covered Accident**. This benefit is not for an epidural or other similar treatment administered during a surgical procedure [or for pain management associated with pregnancy].]

[Physical Therapy and Rehabilitation
We will pay [$250] per treatment for [two (2)] treatment(s) per day, up to a maximum of [five (5)] treatment(s) per **Covered Accident**, [per **Covered Person**][for **You**] when [a **Covered Person** receives][**You** receive] emergency treatment for **Injuries** sustained in a **Covered Accident** and later a **Physician** advises [a **Covered Person**][**You**] to seek treatment from a licensed **Physical Therapist**. Physical therapy must be for **Injuries** sustained in a **Covered Accident** and must start within [thirty (30)] days of the **Covered Accident** or discharge from the **Hospital**. The treatment must take place within [six (6)] month(s) after the **Covered Accident**. [The Physical Therapy and Rehabilitation Benefit is not payable on the same day that the Subsequent Emergency Room Treatment Benefit is payable.]]

[Durable Medical Equipment and Prosthetic Appliance
We will pay [$5,000] once per **Covered Accident**, [per **Covered Person**][for **You**] when [a **Covered Person** receives][**You** receive] **Durable Medical Equipment**, prescribed by a **Physician**, as an aid in personal locomotion for **Injuries** sustained in a **Covered Accident**. Benefits are for the following types of equipment: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches. **We** will pay [$5,000] once per **Covered Accident** [per **Covered Person**][to **You**] when [a **Covered Person** require][**You** require] use of a **Prosthetic Appliance** as a result of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to provide a benefit for the repair or replacement of **Prosthetic Appliance** already prescribed for the **Covered Person**, hearing aids, wigs, or dental aids, including false teeth.]

[Blood, Plasma, and or Platelets

We will pay [$2,500] once per **Covered Accident** [per **Covered Person**][to **You**] when [that **Covered Person** receives][**You** receive] blood, plasma, and/or platelets for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to pay for immunoglobulins or other similar treatments.]

[Ambulance
We will pay [$500] when [a **Covered Person** requires][**You** require] **Ambulance** transportation and [$5,000] when [that **Covered Person** requires][**You** require] air ambulance transportation to a **Hospital** for **Injuries** sustained in a **Covered Accident.** Air Ambulance services must take place within [forty-eight (48)] hours of the **Covered Accident**. **Ambulance** transportation must be within [forty-eight (48)] hours of the **Covered Accident**. A licensed professional ambulance company must provide the ambulance service. A licensed professional air ambulance company must provide the air ambulance service.]

[Transportation
We will pay [$25] per round trip, up to three round trips per calendar year, [per **Covered Person**][to **You**] per round trip to a **Hospital** when [a **Covered Person** requires][**You** require] **Hospitalization** or **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident**. This benefit may also be used; if a covered **Dependent Child** requires **Hospitalization** or **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident,** if commercial travel is necessary and such **Dependent Child** is accompanied by a person **Related** to [the **Covered Person**][**You**]. This benefit is not for transportation to any **Hospital** located within a [fifty (50)]-mile radius from the site of the **Covered Accident** or the residence of [the **Covered Person**][**You**]. The local attending **Physician** must prescribe the treatment requiring **Hospitalization** or **Hospital Confinement**, and the treatment must not be available locally. This benefit is not for transportation by ambulance or air ambulance to the **Hospital**.]

[Accommodations During Hospital Confinement
We will pay [$50] per night, limited to one motel/hotel room per night, up to [five (5)] days per **Covered Accident** for one motel/hotel room for a member of the immediate family who accompanies [a **Covered Person**][**You**] when admitted for **Hospitalization** or **Hospital Confinement** for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is paid only during the same period of time [the injured **Covered Person** is][**You** are] confined to the **Hospital**. The **Hospital** and motel or hotel must be more than [fifty (50)] miles from [the **Covered Person's**] [**Your**] residence.]

Limitations and Exclusions

For purposes of this rider only, the following additional exclusions apply:

1. **We** will not pay benefits for services rendered by a person **Related** to [the **Covered Person**][**You**].
2. **We** will not pay benefits for treatment or loss due to **Sickness**, including
    a. any bacterial, viral, or microorganism infection or infestation, or
    b. any condition resulting from insect, arachnid, or other arthropod bites or stings; or
    c. an error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any **Sickness**.
3. **We** will not pay benefits for cosmetic surgery or other elective procedures that are not **Medically Necessary** or are unrelated to the **Injury** caused by the **Covered Accident**.
4. **We** will not pay benefits for dental treatment except as a result of a **Covered Injury**.

For purposes of this rider only, the following additional definitions apply:

[**Ambulance** means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded. Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]

[**Durable Medical Equipment** means equipment or apparatus of a type that is designed primarily for use, and used primarily, to assist persons suffering from illnesses or injuries that restrict their normal mobility and function and includes equipments such as a wheelchair or a hospital bed. It does not include items commonly used by persons that are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health such as a stationary bicycle or a spa.]

Chip Fracture means a **Fracture** in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached. It must be diagnosed by a **Physician** through the use of an X-ray or other similar diagnostic exam.

Coma means a continuous state of profound unconsciousness, diagnosed or treated after [the **Covered Person's**] [**Your**] Effective Date of coverage, lasting for a period of seven (7) or more consecutive days, and characterized by the absence of one (1) spontaneous eye movements, two (2) response to painful stimuli, and three (3) vocalization. The condition must require intubation for respiratory assistance. **Coma** does not include medically induced coma.

Dislocation means a completely separated joint due to an **Injury**. The **Dislocation** must be diagnosed by a **Physician** [within seventy-two (72) hours] after the date of the **Injury** and require correction by a **Physician**.

Fracture means a break in a bone due to an **Injury** and that can be seen by X-ray or other similar diagnostic exam. The **Fracture** must be diagnosed by a **Physician** [within fourteen (14) days after the date of the **Covered Injury**] and require correction by a **Physician**.

Hospital means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides 24-hour nursing service by or under the supervision of graduate registered nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism, or substance abuse.

However, a place for the treatment of mental illness, alcoholism, or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the above requirements; and
2. listed in the American Hospital Association Guide as a general **Hospital**.

Hospital Confinement (Hospitalization) means a stay by [the **Covered Person**][**You**] confined to a bed in a **Hospital** for which a room charge is made. The **Hospital Confinement** must be on the advice of a **Physician**, it must be **Medically Necessary**, and the result of **Injuries** sustained in a **Covered Accident** or for rehabilitative care and treatment for **Injuries** sustained in a **Covered Accident**. **Hospital Confinement** also means the period of **Hospital Confinement** that starts while this policy is in force. If the **Hospital Confinement** follows a previously covered **Hospital Confinement**, it will be deemed a continuation of the first **Hospital Confinement** unless one (1) the later **Hospital Confinement** is the result of an entirely unrelated **Injury** or two (2) the **Hospital Confinements** are separated by thirty (30) days or more. **Hospitalization** that begins prior to the end of one calendar year and continues into the next calendar year will be considered one **Hospital Confinement**.

Injury means a bodily **Injury** caused directly by a **Covered Accident**, independent of **Sickness**, disease, bodily infirmity, or any other cause, occurring on or after the [**Covered Person's**] [**Your**] Effective Date of coverage and while coverage is in force for [the **Covered Person**][**You**].

Intensive Care Unit (ICU) means a specifically designated facility of the **Hospital** that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The **ICU** must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the **ICU** on a full-time basis. These units must be listed as **Intensive Care Units** in the current edition of the American Hospital Association Guide or be eligible to be listed therein. **ICU** includes Cardiac Intensive Care Units and Infant (Neonatal) Intensive Care Units.

Medically Necessary means that the medical service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Complication** for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. is ordered by a **Physician**.

Physical Therapist means a licensed specialist in physical therapy other than a person **Related** to [the **Covered Person**][**You**].

Prosthetic Appliance means a replacement or artificial substitution for a missing body limb or eye. This does not include a dental prosthetic device such as dentures or crowns.

Reduction means open (surgical) or closed (manipulative) repair of a **Fracture** or **Dislocation**.

Rehabilitation Unit means a unit of a **Hospital** providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a **Physician** who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

Sickness means an illness, disease, infection, or any other abnormal physical condition, independent of **Injury**, occurring on or after **Your** Effective Date of coverage and while coverage is in force for the **Covered Person**. Complications of Pregnancy will be covered to the same extent as a **Sickness**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

Complications of Pregnancy Benefit

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If [a **Covered Person** suffers][**You** suffer] **Covered Complications of Pregnancy** [,other than a **Non-elective Cesarean Section**,] resulting from a **Covered Accident**, **We** will pay the [coinsurance percentage of the] [**Usual and Customary**] expenses for **Medically Necessary** Covered Medical Service(s) incurred up to the Maximum Amount as shown on the Schedule. [The Maximum Amount is the amount payable per calendar year for all **Covered Complications of Pregnancy** payable under the **Policy**.] This benefit is payable only for such Covered Charges incurred [after the **Deductible**, as shown on the Schedule, has been met and] on or after the date [the **Covered Person** suffers][**You** suffer] the **Covered Complications**. [**Complications of Pregnancy Benefits** are in excess of all other valid and collectible insurance.]

[If the **Covered Complication of Pregnancy** is a **Medically Necessary Non-elective Cesarean Section**, after the applicable **Deductible** has been met and on or after the date the **Non-elective Cesarean Section** is performed, benefits are payable on the same basis as any other **Covered Complications** for Covered Charges incurred, up to the Maximum Amount shown in the Schedule.]

[Additional Benefit
If the [**Covered Person's]** [**Your**] coverage terminates solely due to the birth of a child, an Additional Benefit will be provided for [six (6)][weeks][months] from the date of termination for [**Covered Complications**] [and] [postpartum depression] resulting solely from that **Covered Accident**. This benefit is payable only for such Covered Charges incurred [after the applicable **Deductible**, as shown on the Schedule, has been met and] on or after the date [the **Covered Person** suffers][**You** suffer] the **Covered Complication(s)**, subject to the Additional Benefit amount shown on the Schedule. [The over all Maximum Amount for **Complications of Pregnancy** payable per calendar year will be reduced by the amount paid under this Additional Benefit.] Benefits provided under this rider are subject to all other terms and limitations of the **Policy**.]

For purposes of this rider only, the following additional definitions apply:

Alcohol and Substance Abuse means the overindulgence or dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's welfare or the welfare of others.

Covered Complications of Pregnancy (Covered Complications) means any of the following conditions requiring [treatment by a **Physician**] [**Hospital Confinement**] [when the pregnancy is not terminated] whose diagnoses are distinct from but adversely affected by pregnancy or caused by pregnancy, including:

1. acute nephritis;
2. nephrosis;
3. cardiac decompensation;
4. missed abortion; [and]
5. similar medical and surgical conditions of comparable severity; [and]
6. [**Non-Elective Cesarean Section**;] [and]
7. [spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.]

Covered Complications of Pregnancy do not include false labor, occasional spotting, [**Physician**-prescribed rest during the period of pregnancy,] morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

[**Deductible** means the amount of **Usual and Customary Expenses** for **Medically Necessary** treatment of [**Covered Complications**][**Non-elective Cesarean Sections**] that must be incurred by the [**Covered Person**][**You**] before [**Covered Complications**][**Non-elective Cesarean Section**] benefits become payable. The amount of the **Deductible** is shown in the Schedule. **Complications of Pregnancy** benefits are not payable for charges applied to the **Deductible**.]

Durable Medical Equipment means equipment or apparatus of a type that is designed primarily for use, and used primarily, to assist persons suffering from illnesses or injuries that restrict their normal mobility and function and includes equipments such as a wheelchair or a hospital bed. It does not include items commonly used by persons that are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health such as a stationary bicycle or a spa.

Experimental or Investigative Treatment means treatment, a device or prescription medication which is recommended by a **Physician**, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device, or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice, and any items requiring federal or other government agency approval for which approval is not yet received at the time the services are rendered.

Hospital means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides 24-hour nursing service by or under the supervision of graduate registered nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism, or substance abuse.

However, a place for the treatment of mental illness, alcoholism, or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the above requirements; and
2. listed in the American Hospital Association Guide as a general **Hospital**.

Hospital Confined (**Hospital Confinement**) means admission to a **Hospital** as an inpatient [for at least twenty-four (24) consecutive hours] by a **Physician** for a **Covered Complication**. A **Hospital** stay that does not result in charges to the [**Covered Person**][**You**] is not a **Hospital Confinement** under this rider unless there is no charge because the **Hospital** is a United States government facility.

Medically Necessary means that the medical service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Complication** for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. is ordered by a **Physician**.

[**Non-Elective Cesarean Section** means an unscheduled cesarean section due to an emergency which puts the life and health of the [**Covered Person**] [**You**] or fetus in jeopardy.]

Pre-existing Condition means a condition for which a [**Covered Person**] [**You**] received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [six (6)] months immediately preceding the **Covered Complication** [unless the condition for which the prescribed medication is taken remains controlled without any change in the required prescription].

[**Usual and Customary Expense(s)** (**Covered Charges**) means an amount(s) that: (1) is made for a **Covered Complication of Pregnancy**, (2) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and (3) does not include charges that would not have been made if no insurance existed [and (4) does not exceed the cost of a generic drug, if available. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available.]

For purposes of this rider only, Section VII Termination of Insurance is amended and replaced by the following:

A. Policy Renewal and Termination.

Renewal. This **Policy** is guaranteed renewable [until **You** reach age [seventy (70)]]. **We** cannot change any of the terms of this **Policy**, except that, in the future, **We** may increase the premium **You** pay.

You may terminate this **Policy** at any time by delivering to **Us** a written notice to end this **Policy** effective on receipt or such later date as **You** specify in the notice. **We** will calculate and return the unearned premium, if any, using a standard short rate table. **You** must send **Us** any additional amounts owed, if any, between the **Policy's** paid to date and the official date of termination.

This **Policy** and all insurance for **You** [and **Your Dependents**] will terminate on the earliest of the following:

1. On any premium due date if the payment is not received prior to the end of the Grace Period;
2. On the date **You** reach age [seventy (70)];
3. On the date of **Your** death;
4. On the birth of a child as a result of a **Covered Accident**;
5. On the date there is fraud or a material misrepresentation made by or with the knowledge of any **Covered Person** in filing a claim for benefits.

B. [Termination of **Dependent's** Insurance.

All insurance for a **Dependent** will terminate on the earliest of the following:

1. On the date that this **Policy** is terminated;
2. On any premium due date if the premium for that **Dependent** is not received prior to the end of the Grace Period;
3. On the date the **Dependent** reaches age [seventy (70)];
4. On the date of the birth of a child as a result of a **Covered Accident;**
5. On the first premium due date following the date the person no longer qualifies as a **Dependent**.]

Termination of this **Policy** or of any **Covered Person's** coverage will be without prejudice to any claim which commenced prior to the effective date of termination.

EXCLUSIONS:

For purposes of this rider only and in addition to the General Exclusions stated in Section IV of the **Policy**, **We** will not provide coverage for any of the following:

[1. routine examinations for pregnancy screening and testing.]

[2. routine physical examination and related medical services.]

[3. post-partum depression, except as specifically provided in the **Policy**.]

[4. rental of **Durable Medical Equipment** where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (if, in **Our** sole judgment, **Complications of Pregnancy** benefits for rental of **Durable Medical Equipment** are expected to exceed the

usual purchase expense for similar equipment in the locality where the expense is incurred, **We** may, but are not required to, choose to consider such purchase expense as a **Covered Charge** in lieu of such rental expense).]

[5. personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals while confined in a **Hospital** [or for items taken away or home from the **Hospital**, [including but not limited to crutches, wheel chairs and walkers] [except **Durable Medical Equipment**]].]

[6. expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.]

[7. any expenses for a **Pre-existing Condition** until twelve (12) months after the effective date of this Rider.]

[8. elective abortion.]

[9. elective or cosmetic, plastic or restorative surgery.]

[10. any condition for which the [**Covered Person** is][**You** are] entitled to benefits under any mandatory no-fault automobile insurance.]

[11. charges that are payable under automobile medical benefits [in excess of [$5,000]].]

[12. the cost of actual procedures relating to the testing, harvesting, and implantation of human eggs (oocytes).]

[13. care, treatment, or services provided by any person **Related** to the [**Covered Person**][**You**].

[14. **Experimental or Investigative Treatment** or procedures.]

[15. diagnostic tests or treatment, except due to a **Complication of Pregnancy**.]

[16. care, treatment or services provided by persons retained or employed by the [**Covered Person**][**You**]; or for supplies, prescriptions or medicines paid for or reimbursable for the [**Covered Person**][**You**], or for which a charge is not made.]

[17. normal pregnancy or child birth.]

[18. treatment for a newborn child.]

[19. treatment for in vitro fertilization, infertility, fertility studies, sexual transformation, sexual dysfunction.]

[20. any expenses, services or treatment for any form of food supplement or augmentation (unless **Medically Necessary**), or for any exercise program for weight control, whether for obesity or any other diagnosis and whether by diet, injection of any fluid, or use of any medications or surgery of any kind.]

[21. sexually transmitted diseases, including, but not limited to: herpes, gonorrhea, syphilis, cytomegalovirus, or any disability attributable, directly or indirectly, to Human Immunodeficiency Virus (HIV), and/or related illness including Acquired Immune Deficiency Syndromes (AIDS), or any mutant derivative thereof.]

[22. non-prescription drugs which include, but are not limited to: vitamins, tonic, nutritional supplements, biochemical or herbal remedies.]

[23. any loss incurred while outside the United States, its territories or Canada.]

[24. alcoholism, drug addiction or being under the influence of any controlled substance unless administered on the advice of a **Physician**.]

[25. riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.]

[26. any action that may pose a health risk to the fetus, including, but not limited to: handling or changing cat litter, smoking cigarettes or remaining in the presence of secondhand smoke for extended periods of time.]

[27. engaging in high-impact sports or any other similar activities that may pose a health risk to the fetus, including but not limited to: mountaineering, rappelling, horsemanship, rafting, sky-diving, bungee cord jumping.]

[28. undergoing x-rays (except on an emergency basis) or chiropractic treatment without the prior written approval of a **Physician**.]

[29. obtaining any permanent body tattooing or piercing any part of the [**Covered Person's**] [**Your**] body.]

[30. use of any illegal drugs or use of any non-prescription medications or any prescription drug, narcotic, or hallucinogen, without consent of a **Physician** or in excess of the approved dosage.]

[31. **Complications of Pregnancy** arising from travel outside of the [**Covered Person's**] [**You**] state of residence during the final trimester of pregnancy.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of **Policy** No. _____

SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

Rate Information

Rate data applies to filing.

Filing Method:	Prior approval
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Zurich American Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved 01/31/2012	Exhibit I Rating Structure	U-IMC-109-A, U-IMC-123-A, U-IMC-124-A, U-IMC-131-A, U-IMC-139-A, U-IMC-141-A, U-IMC-147-A, U-IMC-148-A, U-IMC-149-A, U-IMC-153-A, U-IMC-161-A, U-IMC-171-A, U-IMC-172-A, U-IMC-173-A, U-IMC-174-A, U-IMC-175-A, U-IMC-176-A, U-IMC-177-A, U-IMC-178-A	New		ZNA02.IMC.v1.2.50%.Rates.20120112.pdf

Exhibit I
Zurich American Insurance Company
Additional Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children Benefit U-IMC-109-A
Annual Premiums

Benefit	Unit of Principle Sum	Percent of Principle Sum	Percent of Accidental Death Rate*	Annual Premium per Unit
Accidental Dismemberment	$1,000	Varies**	3.75%	$0.02400
Loss of Use	$1,000	Varies***	1.73%	$0.01107
Plegia	$1,000	Varies****	1.96%	$0.01254

**Pro-Rate for Other Maximum Benefits*

**Accidental Dismemberment: Covered Loss	Percent of Principle Sum
Both Hands or Both Feet	50%
One Hand and One Foot	50%
One Hand or One Foot plus the loss of Sight of One Eye	50%
Sight of Both Eyes	50%
Speech and Hearing	50%
Speech or Hearing	25%
One Hand; One Foot; or Sight of One Eye	25%
Thumb and Index Finger of the same Hand	12.5%
Hearing in One Ear	12.5%

***Loss of Used: Covered Loss	Percent of Principle Sum
4 Limbs	50%
3 Limbs	37.5%
2 Limbs	33.3%
1 Limb	25%

****Plegia: Covered Loss	Percent of Principle Sum
Quadriplegia	50%
Triplegia	37.5%
Paraplegia	33.3%
Hemiplegia	25%
Uniplegia	12.5%

Exhibit I
Zurich American Insurance Company
After School Care Benefit U-IMC-123-A
Annual Premiums

Benefit	Annual Premium*
After School Care Benefit	$0.86938

*Based on $2,000 maximum benefit.
Prorate for other maximum benefits.

Maximum Age Adjustment

Maximum Age	Adjustment Factor
4	0.315
5	0.377
6	0.438
7	0.497
8	0.557
9	0.617
10	0.679
11	0.741
12	0.804
13	0.868
14	0.934
15	1.000

Annual premium is for 1 year of benefit. For other benefit durations, multiply premium by benefit duration.

Exhibit I
Zurich American Insurance Company
Inflation Benefit U-IMC-124-A
Annual Premium Rate Load Factors*

Benefit Increase	Maximum Number of Increases				
	1	5	10	15	20
5%	1.0208	1.0512	1.0566	1.0572	1.0573
10%	1.0416	1.1023	1.1133	1.1144	1.1146
15%	1.0624	1.1535	1.1699	1.1717	1.1718
20%	1.0832	1.2047	1.2266	1.2289	1.2291

* Load factors should be multiplied by the total premium of all benefits covered by the inflation benefit rider.

Exhibit I
Zurich American Insurance Company
HIV Occupational Accident Benefit U-IMC-131-A
Annual Premiums

Benefit	Unit	Annual Premium per Unit
HIV Occupational Accident Benefit	$1,000	$0.033

Adjustment Factor for Different Incurral Periods Following Accident

Time for Loss to Occur	30 Days	90 Days	180 Days	365 Days	730 Days
Adjustment Factor	0.990	1.000	1.020	1.050	1.100

Exhibit I
Zurich American Insurance Company
[Permanent] [Temporary] Total Disability Benefit U-IMC-139-A
Annual Premiums

Annual Premiums per $1,000 Monthly Benefit

Benefit Period (Months)	Benefit Waiting Period	
	6 Months	12 Months
6	8.11	5.71
12	13.81	10.63
18	18.72	15.18
24	23.27	19.47
36	31.59	27.40
48	39.13	34.64
60	46.05	41.31

Annual Premiums per $1,000 Lump Sum Benefit

Benefit Waiting Period	
6 Months	12 Months
2.06	1.14

Exhibit I
Zurich American Insurance Company
Critical Burn Benefit U-IMC-141-A
Annual Premiums

Benefit	Unit	Annual Premium per Unit
Critical Burn Benefit	$1,000	$0.127

Adjustment for Percent of Body Burned

Percent of Body Burned	Adjustment Factor
10%	8.584
20%	2.187
25%	1.000
30%	0.713
40%	0.317
50%	0.160
60%	0.093
70%	0.055
80%	0.028

Adjustment Factor for Different Incurral Periods Following Accident

Time for Loss to Occur	90 Days	180 Days	365 Days
Adjustment Factor	1.000	1.020	1.050

Exhibit I
Zurich American Insurance Company
Continuation of Insurance Benefit U-IMC-147-A
Annual Premium Rate Load Factors*

Benefit	Load Factor
Continuation of Insurance Benefit	1.00032

* Load factors should be multiplied by the total premium
of all benefits covered by the continuation of insurance rider.

Exhibit I
Zurich American Insurance Company
Day Care Benefit U-IMC-148-A
Annual Premiums

Benefit	Unit*	Annual Premium per Unit
Day Care Benefit	$1,000	$0.307

*Day Care Benefit is the lesser of:
(1) The cost of the day care (Average Cost is $3,432 per year)
(2) Percentage of the AD benefit
(3) Specified benefit amount

Maximum Age Adjustment

Maximum Age	Adjustment Factor
2	0.219
3	0.291
4	0.362
5	0.434
6	0.504
7	0.573
8	0.641
9	0.711
10	0.782
11	0.853
12	0.926
13	1.000
14	1.075
15	1.152
16	1.230
17	1.305
18	1.379

Exhibit I
Zurich American Insurance Company
Hearing Aid or Prosthetic Appliance Benefit U-IMC-149-A
Annual Premiums

Maximum Beneft	Annual Premium
$1,000	0.0209
$2,500	0.0313
$5,000	0.0374
$10,000	0.0412
$15,000	0.0425
$20,000	0.0431
$25,000	0.0435
$30,000	0.0438
$40,000	0.0440
$50,000	0.0441

Adjustment Factor for Different Incurral Periods Following Accident

Time for Loss to Occur	90 Days	120 Days	180 Days	365 Days	730 Days
Adjustment Factor	0.950	0.955	1.020	1.050	1.100

Exhibit I
Zurich American Insurance Company
Emergency [Transportation] [and] [Treatment] [and] Hospital Cash Benefit U-IMC-153-A
Annual Premiums

Benefit	Unit	Annual Premium per Unit
Emergency Transportation Benefit	$1,000	$17.91
Emergency Treatment Benefit	$1,000	$139.40
Emergency Hospital Cash	$100	Varies*

*Emergency Hospital Cash Annual Premiums per $100 Daily Benefit

Waiting Period (Days)	Benefit Period (Days)					
	1	7	14	30	60	90
1	2.0281	8.0014	9.3681	10.3115	10.7787	10.9177
2	0.9703	4.6695	5.6149	6.2674	6.5905	6.6867
3	0.4510	2.5519	3.1964	3.6413	3.8616	3.9271
4	0.2266	1.4365	1.8933	2.2086	2.3648	2.4112
5	0.1285	0.8710	1.2150	1.4525	1.5701	1.6050
6	0.0779	0.5455	0.8134	0.9983	1.0899	1.1171
7	0.0479	0.3354	0.5454	0.6904	0.7622	0.7836
8	0.0316	0.2209	0.3841	0.5017	0.5600	0.5773
9	0.0221	0.1544	0.2822	0.3806	0.4293	0.4438
10	0.0159	0.1111	0.2109	0.2943	0.3356	0.3479

Emergency Treatment within 24, 48, 72 hours of Accident

Time for Loss to Occur	24 Hours	48 Hours	72 Hours
Adjustment Factor	0.990	0.995	1.000

Exhibit I
Zurich American Insurance Company
Traumatic Brain Injury Benefit U-IMC-161-A
Annual Premiums

Benefit	Unit	Annual Premium per Unit
Traumatic Brain Injury Benefit	$1,000	$0.59

Adjustment Factor for Different Incurral Periods Following Accident

Time for Loss to Occur	30 Days	60 Days	90 Days	180 Days	365 Days
Adjustment Factor	0.990	0.995	1.000	1.020	1.050

Required Hospitalization Days

Days	Adjustment
7	1.000
8	0.780
9	0.631
10	0.525
11	0.443
12	0.382
13	0.334
14	0.294

Exhibit I
Zurich American Insurance Company
Home Alteration and Vehicle Modification Benefit U-IMC-171-A
Annual Premiums

Maximum Beneft	Annual Premium
$1,000	0.19
$2,500	0.37
$5,000	0.57
$10,000	0.81
$15,000	0.96
$20,000	1.08
$25,000	1.17
$30,000	1.24
$40,000	1.35
$50,000	1.44

Exhibit I
Zurich American Insurance Company
Natural Disaster Benefit U-IMC-172-A
Annual Premiums

Natural Disaster Benefit	Unit	Annual Premium per Unit
Accidental Death	$1,000	$0.003539
Accidental Dismemberment	$1,000	$0.000265
Loss of Use	$1,000	$0.000122
Plegia	$1,000	$0.000139

Exhibit I
Zurich American Insurance Company
[Occupational] [or] [Voluntary Activity] Hepatitis Benefit U-IMC-173-A
Annual Premiums

Annual Premiums, per $1,000 Monthly Benefit, with Hepatitis A

Benefit Period (Months)	Annual Premium per $1,000 Monthly Benefit	Benefit Period (Months)	Annual Premium per $1,000 Monthly Benefit
1	0.0214	91	0.4055
2	0.0384	92	0.4083
3	0.0509	93	0.4112
4	0.0610	94	0.4140
5	0.0688	95	0.4168
6	0.0741	96	0.4196
7	0.0793	97	0.4224
8	0.0845	98	0.4252
9	0.0896	99	0.4279
10	0.0946	100	0.4306
11	0.0995	101	0.4333
12	0.1043	102	0.4360
13	0.1092	103	0.4386
14	0.1140	104	0.4413
15	0.1187	105	0.4439
16	0.1235	106	0.4465
17	0.1282	107	0.4490
18	0.1329	108	0.4516
19	0.1375	109	0.4541
20	0.1421	110	0.4566
21	0.1467	111	0.4591
22	0.1513	112	0.4616
23	0.1558	113	0.4641
24	0.1604	114	0.4665
25	0.1648	115	0.4689
26	0.1693	116	0.4713
27	0.1737	117	0.4737
28	0.1781	118	0.4760
29	0.1825	119	0.4784
30	0.1869	120	0.4807
31	0.1912	121	0.4830
32	0.1955	122	0.4853
33	0.1998	123	0.4876
34	0.2040	124	0.4898
35	0.2082	125	0.4921
36	0.2124	126	0.4943
37	0.2166	127	0.4965
38	0.2207	128	0.4986
39	0.2248	129	0.5008
40	0.2289	130	0.5029
41	0.2330	131	0.5051
42	0.2370	132	0.5072
43	0.2410	133	0.5093
44	0.2450	134	0.5113
45	0.2490	135	0.5134
46	0.2529	136	0.5154
47	0.2568	137	0.5174
48	0.2607	138	0.5194
49	0.2646	139	0.5214
50	0.2684	140	0.5234
51	0.2722	141	0.5253
52	0.2760	142	0.5273
53	0.2798	143	0.5292
54	0.2835	144	0.5311
55	0.2872	145	0.5330
56	0.2909	146	0.5348
57	0.2946	147	0.5367
58	0.2982	148	0.5385
59	0.3018	149	0.5403
60	0.3054	150	0.5421
61	0.3090	151	0.5439
62	0.3125	152	0.5457
63	0.3161	153	0.5474
64	0.3196	154	0.5491
65	0.3230	155	0.5509
66	0.3265	156	0.5526
67	0.3299	157	0.5542
68	0.3333	158	0.5559
69	0.3367	159	0.5576
70	0.3401	160	0.5592
71	0.3434	161	0.5608
72	0.3467	162	0.5624
73	0.3500	163	0.5640
74	0.3533	164	0.5656
75	0.3565	165	0.5671
76	0.3597	166	0.5687
77	0.3629	167	0.5702
78	0.3661	168	0.5717
79	0.3693	169	0.5732
80	0.3724	170	0.5747
81	0.3755	171	0.5762
82	0.3786	172	0.5776
83	0.3817	173	0.5791
84	0.3847	174	0.5805
85	0.3878	175	0.5819
86	0.3908	176	0.5833
87	0.3937	177	0.5847
88	0.3967	178	0.5860
89	0.3996	179	0.5874
90	0.4026	180	0.5887

Annual Premiums, per $1,000 Monthly Benefit, without Hepatitis A

Benefit Period (Months)	Annual Premium per $1,000 Monthly Benefit	Benefit Period (Months)	Annual Premium per $1,000 Monthly Benefit
1	0.0153	91	0.3880
2	0.0286	92	0.3908
3	0.0399	93	0.3936
4	0.0491	94	0.3964
5	0.0563	95	0.3992
6	0.0616	96	0.4020
7	0.0667	97	0.4047
8	0.0718	98	0.4074
9	0.0768	99	0.4101
10	0.0817	100	0.4128
11	0.0866	101	0.4155
12	0.0913	102	0.4181
13	0.0961	103	0.4207
14	0.1008	104	0.4233
15	0.1055	105	0.4259
16	0.1101	106	0.4285
17	0.1148	107	0.4310
18	0.1194	108	0.4336
19	0.1239	109	0.4361
20	0.1285	110	0.4386
21	0.1330	111	0.4410
22	0.1375	112	0.4435
23	0.1420	113	0.4459
24	0.1464	114	0.4483
25	0.1508	115	0.4507
26	0.1552	116	0.4531
27	0.1596	117	0.4554
28	0.1639	118	0.4578
29	0.1682	119	0.4601
30	0.1725	120	0.4624
31	0.1768	121	0.4647
32	0.1810	122	0.4669
33	0.1852	123	0.4692
34	0.1894	124	0.4714
35	0.1935	125	0.4736
36	0.1977	126	0.4758
37	0.2018	127	0.4780
38	0.2058	128	0.4801
39	0.2099	129	0.4823
40	0.2139	130	0.4844
41	0.2179	131	0.4865
42	0.2219	132	0.4886
43	0.2258	133	0.4907
44	0.2298	134	0.4927
45	0.2337	135	0.4948
46	0.2375	136	0.4968
47	0.2414	137	0.4988
48	0.2452	138	0.5008
49	0.2490	139	0.5027
50	0.2528	140	0.5047
51	0.2566	141	0.5066
52	0.2603	142	0.5085
53	0.2640	143	0.5104
54	0.2677	144	0.5123
55	0.2713	145	0.5142
56	0.2750	146	0.5160
57	0.2786	147	0.5179
58	0.2822	148	0.5197
59	0.2857	149	0.5215
60	0.2893	150	0.5233
61	0.2928	151	0.5251
62	0.2963	152	0.5268
63	0.2998	153	0.5286
64	0.3032	154	0.5303
65	0.3066	155	0.5320
66	0.3100	156	0.5337
67	0.3134	157	0.5354
68	0.3168	158	0.5370
69	0.3201	159	0.5387
70	0.3234	160	0.5403
71	0.3267	161	0.5419
72	0.3300	162	0.5435
73	0.3332	163	0.5451
74	0.3364	164	0.5467
75	0.3397	165	0.5482
76	0.3428	166	0.5498
77	0.3460	167	0.5513
78	0.3491	168	0.5528
79	0.3522	169	0.5543
80	0.3553	170	0.5558
81	0.3584	171	0.5572
82	0.3615	172	0.5587
83	0.3645	173	0.5601
84	0.3675	174	0.5615
85	0.3705	175	0.5629
86	0.3734	176	0.5643
87	0.3764	177	0.5657
88	0.3793	178	0.5671
89	0.3822	179	0.5684
90	0.3851	180	0.5698

Adjustment Factor for Different Incurral Periods Following Accident

Time for Loss to Occur	30 Days	90 Days	180 Days	365 Days	730 Days
Adjustment Factor	0.990	1.000	1.020	1.050	1.100

Exhibit I
Zurich American Insurance Company
Recuperation Benefit U-IMC-174-A
Annual Premiums

Waiting Period (Days)	Annual Premiums per $100 daily benefit
0	15.2508
1	11.0102
2	6.7506
3	3.9707
4	2.4421
5	1.6283
6	1.1352
7	0.7978
8	0.5889
9	0.4535
10	0.3561
11	0.2870
12	0.2369
13	0.1968
14	0.1622
15	0.1379
16	0.1181
17	0.1024
18	0.0894
19	0.0790
20	0.0669
21	0.0548
22	0.0427
23	0.0393
24	0.0358
25	0.0323
26	0.0288
27	0.0253
28	0.0235
29	0.0217
30	0.0199

Exhibit I
Zurich American Insurance Company
Student [Tuition] [and] [Expense] Reimbursement Benefit U-IMC-175-A
Annual Premiums

Student Loan Reimbursement

Benefit Trigger	Annual Premium
Accidental Death	11.74
Accidental Dismemberment	0.88
Critical Illness:	
Cancer	9.32
Heart Attack	2.67
Kidney Failure	1.33
Loss of Limb	1.44
Major Organ Transplan	2.74
Paralysis	1.57
Stroke	0.68
Total	32.36

Maximum Benefit	Adjustment Factor
100	0.004
1,000	0.036
2,500	0.090
5,000	0.180
7,500	0.270
10,000	0.360
15,000	0.540
20,000	0.698
25,000	0.805
50,000	0.992
100,000	1.000

Tuition Reimbursement

Benefit Trigger	Annual Premium per $1,000
Accidental Death	0.64
Accidental Dismemberment	0.05
Critical Illness:	
Cancer	0.51
Heart Attack	0.15
Kidney Failure	0.07
Loss of Limb	0.08
Major Organ Transplan	0.15
Paralysis	0.09
Stroke	0.04
Total	1.76

Student Tuition and Tuition Expense

Benefit Trigger	Annual Premium
Accidental Death	6.86
Accidental Dismemberment	0.51
Critical Illness:	
Cancer	5.44
Heart Attack	1.56
Kidney Failure	0.78
Loss of Limb	0.84
Major Organ Transplan	1.60
Paralysis	0.92
Stroke	0.40
Total	18.91

Maximum Benefit	Adjustment Factor
100	0.009
1,000	0.093
2,500	0.233
5,000	0.422
7,500	0.560
10,000	0.660
15,000	0.788
20,000	0.879
25,000	0.951
50,000	1.000

Maximum Number of Payments	Adjustment Factor
1	1.00
2	1.65
3	2.29
4	2.80
5	3.19
6	4.11
7	4.36
8	4.48
9	4.49
10	4.50
11	4.51
12	4.52
13	4.53
14	4.54
15	4.55
16	4.56

Student Expense

Benefit Trigger	Annual Premium
Accidental Death	7.27
Accidental Dismemberment	0.55
Critical Illness:	
Cancer	5.77
Heart Attack	1.65
Kidney Failure	0.82
Loss of Limb	0.89
Major Organ Transplan	1.70
Paralysis	0.97
Stroke	0.42
Total	20.03

Maximum Benefit	Adjustment Factor
100	0.009
1,000	0.088
2,500	0.220
5,000	0.440
7,500	0.660
10,000	0.880
15,000	1.000
20,000	1.050
25,000	1.100
50,000	1.150

Maximum Number of Payments	Adjustment Factor
1	1.00
2	1.65
3	2.29
4	2.80
5	3.19
6	4.11
7	4.36
8	4.48
9	4.49
10	4.50
11	4.51
12	4.52
13	4.53
14	4.54
15	4.55
16	4.56

Exhibit I
Zurich American Insurance Company
Accelerated Payment Benefit U-IMC-176-A
Annual Premiums

Benefit	Annual Premium per Unit
Accelerated Payment Benefit	No Additional Cost

Exhibit I
Zurich American Insurance Company
Accident Medical Expense - Indemnity Benefit U-IMC-177-A
Annual Premiums

Emergency Room

Benefit	Unit	Annual Premium Per Unit
Emergency Room Benefit	$500	$60.04

Emergency Treatment within 12, 24, 48, 72, 96 hours of Accident

Time for Loss to Occur	12 Hours	24 Hours	48 Hours	72 Hours	96 Hours
Adjustment Factor	0.9875	0.9900	0.9950	1.0000	1.0050

X-Rays Related to an Accident

Benefit	Unit	Annual Premium per Unit
X-rays Related to Accident Benefit	$500	$20.29

Emergency Room Follow Up Treatment

Maximum Days Per Accident	Annual Premiums per $500 benefit
2	$51.26
3	$66.55
4	$79.06
5	$87.57
6	$93.48

Emergency Treatment within 12, 24, 48, 72, 96 hours of Accident

Time for Loss to Occur	12 Hours	24 Hours	48 Hours	72 Hours	96 Hours
Adjustment Factor	0.9875	0.9900	0.9950	1.0000	1.0050

Adjustment Factor for Different Incurral Periods Following Accident

Time for Loss to Occur	10 Days	30 Days	60 Days	90 Days
Adjustment Factor	0.983	0.990	0.995	1.000

Accident Hospitalization

Benefit	Unit	Annual Premium Per Unit
Hospital Confinement	$500	$9.38
Hospital ICU	$500	$0.75

Adjustment Factor for Different Incurral Periods Following Accident

Time for Loss to Occur	10 Days	30 Days	60 Days	90 Days
Adjustment Factor	0.983	0.990	0.995	1.000

Dislocations

Joint Area	Open Reduction Unit	Closed Reduction Unit	Open Annual Premium per Unit	Closed Annual Premium per Unit
Hip	$2,500	$500	$0.5108	$1.2446
Knee	$2,500	$500	$0.0825	$0.2011
Shoulder	$2,500	$500	$0.0478	$0.1164
Collar Bone	$2,500	$500	$0.0239	$0.0582
Ankle or Foot	$2,500	$500	$0.1651	$0.4022
Lower Jaw	$2,500	$500	$0.0498	$0.1214
Wrist	$2,500	$500	$0.0249	$0.0607
Elbow	$2,500	$500	$0.0249	$0.0607
Toe	$2,500	$500	$0.0651	$0.1587
Finger	$2,500	$500	$0.0651	$0.1587

Burns

Body Surface Area	Unit	Annual Premium for 2nd Degree Burns	Unit	Annual Premium for 3rd Degree Burns
Less than 50 square centimeters	$2,500	$0.93	$5,000	$1.15
More than 100 but less than 150 square centimeters	$2,500	$0.90	$5,000	$1.11
More than 150 but less than 200 square centimeter	$2,500	$0.88	$5,000	$1.09
More than 200 but less than 250 square centimeters	$2,500	$0.87	$5,000	$1.07
More than 250 but less than 300 square centimeter	$2,500	$0.85	$5,000	$1.06
More than 300 square centimeters	$2,500	$0.84	$5,000	$1.04

Emergency Treatment within 12, 24, 48, 72, 96 hours of Accident

Time for Loss to Occur	12 Hours	24 Hours	48 Hours	72 Hours	96 Hours
Adjustment Factor	0.9875	0.9900	0.9950	1.0000	1.0050

Skin Grafts

Body Surface Area	Percentage of Burn Benefit	Annual Premium for 2nd Degree Burns	Annual Premium for 3rd Degree Burns
Less than 50 square centimeters	75%	$0.696	$0.860
More than 100 but less than 150 square centimeter	75%	$0.673	$0.833
More than 150 but less than 200 square centimeter	75%	$0.662	$0.819
More than 200 but less than 250 square centimeter	75%	$0.651	$0.806
More than 250 but less than 300 square centimeter	75%	$0.640	$0.792
More than 300 square centimeters	75%	$0.629	$0.778

Eye Injury

Benefit	Unit	Annual Premium per Unit
Surgical Repair	$1,000	$0.66
Removal of Foreign Body	$250	$0.16

Lacerations

Benefit	Unit	Annual Premium per Unit
Not requiring sutures and treated by a Physician	$500	$6.20
Less than 5 centimeters in length	$500	$3.10
At least 5 centimeters but not more than 15 centimeters	$500	$2.07
Over 15 centimeters	$500	$1.03

Exhibit I
Zurich American Insurance Company
Accident Medical Expense - Indemnity Benefit U-IMC-177-A
Annual Premiums

Fractures

Fracture Area	Open Reduction Unit	Closed Reduction Unit	Open Annual Premium per Unit	Closed Annual Premium per Unit
Hip	$100	$100	$0.0169	$0.2812
Leg	$100	$100	$0.0452	$0.7523
Hand (Excluding Fingers	$100	$100	$0.0248	$0.4126
Foot (Excluding Heel/Toes	$100	$100	$0.0188	$0.3124
Wrist	$100	$100	$0.0251	$0.4180
Kneecap	$100	$100	$0.0124	$0.2069
Lower Jaw	$100	$100	$0.0009	$0.0150
Shoulder	$100	$100	$0.0005	$0.0089
Vertebrae (Body of)	$100	$100	$0.0077	$0.1287
Pelvis (Excluding Coccyx	$100	$100	$0.0016	$0.0259
Sternum	$100	$100	$0.0005	$0.0075
Upper Jaw	$100	$100	$0.0005	$0.0089
Upper Arm	$100	$100	$0.0349	$0.5807
Face (Excluding Nose)	$100	$100	$0.0017	$0.0286
Rib	$100	$100	$0.0045	$0.0756
Nose	$100	$100	$0.0009	$0.0143
Heel	$100	$100	$0.0181	$0.3015
Finger	$100	$100	$0.0491	$0.8176
Coccyx	$100	$100	$0.0009	$0.0143
Toe	$100	$100	$0.0354	$0.5893
Vertebral Processes	$100	$100	$0.0077	$0.1287
Skull - Depressed	$100	$100	$0.0015	$0.0252
Skull - Simple	$100	$100	$0.0014	$0.0232

Concussion

Benefit	Unit	Annual Premium per Unit
Concussion Benefit	$100	$0.76

Emergency Dental Procedure

Benefit	Unit	Annual Premium per Unit
Broken tooth repaired with crown	$75	$2.53
Broken tooth resulting in extraction	$75	$1.63

Specified Surgical Procedures Arising From a Covered Accident

Benefit	Unit	Annual Premium per Unit
Arthoscopy without surgical repai	$25	$0.0337
Open abdominal (including exploratory laparotom	$25	$0.0129
Cranial	$25	$0.0114
Herna	$25	$0.0405
Thoraic Surgery	$25	$0.0367
Repair of:	$25	$0.0786
Tendons and/or ligaments		
Torn rotator cuffs		
Ruptured discs		
Torn knee cartilages		

Non-Specified Surgical Procedures Arising From a Covered Accident

Benefit	Unit	Annual Premium per Unit
Miscellaneous Surgery with General Anesthesi	$2,500	$360.01
Other Miscellaneous Surgery with conscious sedatio	$2,500	$301.68

Diagnostic Testing & Exams

Maximum Payments Per Year	Annual Premiums per $2,500 benefit
1	155.06
2	238.56
3	298.75
4	347.39
5	385.78
6	420.60
7	451.83
8	477.17
9	497.65
10	512.25

Pain Management Benefit

Maximum Treatments Per Accident	Annual Premium Per $2,500	
	Without Pregnancy	With Pregnancy
1	$119.935	$138.772
2	$184.526	$213.508
3	$231.078	$267.372
4	$268.700	$310.903
5	$298.402	$345.270
6	$325.331	$376.429
7	$349.489	$404.380
8	$369.092	$427.062
9	$384.932	$445.391
10	$396.219	$458.451

Exhibit I
Zurich American Insurance Company
Accident Medical Expense - Indemnity Benefit U-IMC-177-A
Annual Premiums

Physical Therapy Benefi

Maximum Treatments Per Accident	Annual Premium Per $25 One Treatment Per Day	Two Treatments Per Day
1	$0.816	$1.369
2	$1.369	$2.296
3	$1.777	$2.981
4	$2.111	$3.542
5	$2.338	$3.923
6	$2.496	$4.188
7	$2.630	$4.412
8	$2.723	$4.569
9	$2.789	$4.679
10	$2.848	$4.778

Adjustment Factor for Different Incurral Periods Following Accider

Time for Loss to Occur	10 Days	30 Days	60 Days	90 Days
Adjustment Factor	0.983	0.990	0.995	1.000

Durable Medical Equipment and Prosthetic Applianc

Benefit	Unit	Annual Premium per Unit
Durable Medical Equipmen	$5,000	$483.79
Prosthetic Appliance	$5,000	$4.95

Blood, Plasma, and/or Platelets

Benefit	Unit	Annual Premium per Unit
Blood, Plasma, and or Platelets	$2,500	$23.50

Ambulance

Benefit	Unit	Annual Premium per Unit
Ground Ambulance Benefit	$500	$6.17
Air Ambulance Benefit	$2,500	$6.17

Emergency Treatment within 12, 24, 48, 72, 96 hours of Accident

Time for Loss to Occur	12 Hours	24 Hours	48 Hours	72 Hours	96 Hours
Adjustment Factor	0.9875	0.9900	0.9950	1.0000	1.0050

Transportatior

Benefit	Unit	Annual Premium per Unit
Transportation Benefi	$25	$0.09

Lodging Benefit

Maximum Days Per Accident	Annual Premiums per $50 benefit
5	$0.31
10	$0.62
15	$0.93
20	$1.24
25	$1.55
30	$1.86

Exhibit I
Zurich American Insurance Company
Complications of Pregnancy Benefit U-IMC-178-A
Annual Premiums

95% Coinsurance

Maximum	Deductible										
Benefit	0	25	50	100	250	500	750	1,000	2,500	5,000	10,000
100	0.096	0.095	0.094	0.091	0.083	0.073	0.065	0.059	0.037	0.024	0.014
250	0.230	0.227	0.224	0.218	0.200	0.177	0.158	0.143	0.093	0.060	0.035
500	0.429	0.424	0.418	0.407	0.376	0.334	0.301	0.273	0.181	0.121	0.071
750	0.604	0.596	0.589	0.573	0.532	0.476	0.429	0.392	0.265	0.177	0.106
1,000	0.759	0.750	0.741	0.722	0.674	0.604	0.548	0.502	0.343	0.233	0.141
1,500	1.027	1.016	1.004	0.981	0.919	0.832	0.761	0.703	0.492	0.339	0.206
2,000	1.253	1.240	1.228	1.202	1.130	1.031	0.949	0.882	0.629	0.437	0.271
2,500	1.451	1.437	1.422	1.395	1.317	1.209	1.117	1.042	0.756	0.533	0.335
5,000	2.190	2.173	2.156	2.122	2.028	1.890	1.775	1.678	1.281	0.937	0.609
7,500	2.707	2.688	2.669	2.632	2.528	2.379	2.252	2.140	1.680	1.269	0.844
10,000	3.102	3.083	3.063	3.024	2.916	2.759	2.621	2.502	2.010	1.537	1.050
12,500	3.427	3.407	3.387	3.346	3.233	3.067	2.924	2.799	2.276	1.768	1.231
15,000	3.694	3.673	3.653	3.612	3.497	3.327	3.180	3.052	2.505	1.971	1.394
20,000	4.120	4.099	4.078	4.036	3.919	3.747	3.596	3.462	2.884	2.310	1.675
25,000	4.455	4.434	4.412	4.370	4.250	4.074	3.920	3.784	3.187	2.590	1.903
50,000	5.459	5.437	5.415	5.370	5.246	5.062	4.900	4.756	4.120	3.453	2.668
100,000	6.338	6.315	6.292	6.247	6.121	5.933	5.767	5.619	4.961	4.262	3.414

75% Coinsurance

Maximum	Deductible										
Benefit	0	25	50	100	250	500	750	1,000	2,500	5,000	10,000
100	0.095	0.094	0.093	0.090	0.083	0.073	0.065	0.058	0.037	0.024	0.014
250	0.226	0.223	0.220	0.214	0.197	0.174	0.155	0.142	0.092	0.060	0.035
500	0.414	0.409	0.404	0.393	0.364	0.324	0.292	0.267	0.180	0.119	0.071
750	0.576	0.569	0.562	0.548	0.510	0.457	0.414	0.380	0.259	0.175	0.106
1,000	0.717	0.709	0.700	0.683	0.639	0.576	0.525	0.483	0.336	0.231	0.139
1,500	0.956	0.945	0.935	0.916	0.861	0.784	0.721	0.668	0.476	0.330	0.203
2,000	1.155	1.144	1.133	1.111	1.049	0.964	0.890	0.831	0.603	0.425	0.268
2,500	1.328	1.316	1.304	1.279	1.213	1.120	1.041	0.976	0.720	0.513	0.327
5,000	1.962	1.948	1.933	1.905	1.826	1.712	1.616	1.531	1.188	0.883	0.583
7,500	2.393	2.378	2.362	2.332	2.246	2.122	2.016	1.924	1.537	1.172	0.798
10,000	2.720	2.704	2.688	2.656	2.566	2.436	2.323	2.224	1.811	1.408	0.981
12,500	2.977	2.960	2.944	2.911	2.820	2.686	2.570	2.469	2.034	1.607	1.140
15,000	3.191	3.174	3.158	3.125	3.032	2.896	2.778	2.674	2.223	1.776	1.280
20,000	3.533	3.516	3.499	3.466	3.371	3.232	3.110	3.002	2.530	2.059	1.514
25,000	3.796	3.779	3.762	3.728	3.631	3.489	3.364	3.254	2.771	2.277	1.705
50,000	4.562	4.544	4.526	4.491	4.392	4.245	4.116	4.001	3.490	2.954	2.312
100,000	5.206	5.188	5.170	5.134	5.034	4.885	4.753	4.636	4.113	3.556	2.869

50% Coinsurance

Maximum	Deductible										
Benefit	0	25	50	100	250	500	750	1,000	2,500	5,000	10,000
100	0.094	0.093	0.091	0.089	0.081	0.072	0.064	0.058	0.037	0.024	0.014
250	0.216	0.213	0.210	0.205	0.189	0.168	0.151	0.137	0.091	0.060	0.035
500	0.384	0.379	0.374	0.365	0.340	0.305	0.276	0.253	0.172	0.117	0.071
750	0.521	0.515	0.509	0.498	0.465	0.421	0.385	0.355	0.248	0.171	0.103
1,000	0.637	0.630	0.624	0.610	0.574	0.523	0.481	0.446	0.317	0.220	0.136
1,500	0.830	0.822	0.814	0.799	0.757	0.695	0.646	0.603	0.442	0.313	0.200
2,000	0.987	0.978	0.970	0.953	0.907	0.840	0.784	0.737	0.553	0.397	0.253
2,500	1.121	1.112	1.103	1.085	1.036	0.965	0.905	0.854	0.651	0.474	0.307
5,000	1.596	1.585	1.575	1.555	1.498	1.415	1.344	1.282	1.025	0.781	0.532
7,500	1.902	1.891	1.881	1.859	1.800	1.713	1.637	1.570	1.283	1.006	0.710
10,000	2.127	2.116	2.105	2.083	2.022	1.931	1.852	1.783	1.482	1.184	0.853
12,500	2.305	2.294	2.282	2.260	2.197	2.104	2.023	1.951	1.642	1.328	0.972
15,000	2.449	2.437	2.426	2.403	2.340	2.246	2.164	2.092	1.773	1.447	1.075
20,000	2.670	2.658	2.647	2.624	2.559	2.463	2.379	2.305	1.978	1.638	1.241
25,000	2.837	2.825	2.813	2.790	2.725	2.628	2.542	2.467	2.132	1.785	1.372
50,000	3.305	3.293	3.281	3.258	3.191	3.092	3.005	2.927	2.581	2.213	1.767
100,000	3.666	3.654	3.642	3.618	3.551	3.451	3.362	3.284	2.932	2.556	2.090

SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	01/31/2012

Comments:

Attachment:

U-IMC-100 Certificate of Readability-AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	01/31/2012

Comments:

U-IMC-101-B AR (05/11)
12/22/2011

		Item Status:	Status Date:
Satisfied - Item:	Health - Actuarial Justification	Approved	01/31/2012

Comments:

Attachment:

ZNA02.IMC.v1.2.50%.ActMemo.20120112.pdf

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved	01/31/2012

Bypass Reason: An Outline of Coverage was filed for this product in state tracking number 44259.

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Statement of variables, explanatory memorandum, and redlined copy of	Approved	01/31/2012

SERFF Tracking Number:	*ZURC-128034040*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CW AH 34008*		
TOI:	*H03I Individual Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03I.000 Health - Accidental Death & Dismemberment*
Product Name:	*Individual Accident - Additional Riders*		
Project Name/Number:	*CW AH 34008 - Individual Accident - Additional Riders/CW AH 34008*		

U-IMC-104-A to B

Comments:

Attachments:

U-IMC-1003-A AR - Statement of Variables.pdf

AR U-IMC-1.2 Explanatory Memorandum-01242012.pdf

U-IMC-104-B CWredlined.pdf

Certificate of Readability for Arkansas

Zurich American Insurance Company

I have reviewed or supervised the preparation of the attached policy forms. I hereby certify that to the best of my knowledge, information, and belief, these policy forms comply with the minimum readability standards required by your State Insurance Code.

The policy forms listed below have achieved the following Flesch Scores using the Flesch Reading Ease software published by Micro Power & Light Co.:

Form Number	Title	Flesch Score
U-IMC-104-B CW (09/11)	Administrative Change Endorsement	49
U-IMC-109-A CW (09/11)	Additional Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children Benefit	46
U-IMC-123-A CW (09/11)	After School Care Benefit	49
U-IMC-124-A CW (09/11)	Inflation Benefit	42
U-IMC-131-A CW (09/11)	HIV Occupational Accident Benefit	46
U-IMC-139-A AR (09/11)	[Permanent] [Temporary] Total Disability Benefit	37
U-IMC-141-A CW (09/11)	Critical Burn Benefit	54
U-IMC-147-A CW (09/11)	Continuation of Insurance Benefit	60
U-IMC-148-A CW (09/11)	Day Care Benefit	54
U-IMC-149-A CW (09/11)	Hearing Aid or Prosthetic Appliance Benefit	52
U-IMC-153-A AR (09/11)	Emergency [Transportation] [and] [Treatment] [and] Hospital Cash Benefit	37
U-IMC-161-A AR (09/11)	Traumatic Brain Injury Benefit	47
U-IMC-171-A CW (09/11)	Home Alteration and Vehicle Modification Benefit	42
U-IMC-172-A CW (09/11)	Natural Disaster Benefit	57
U-IMC-173-A CW (09/11)	[Occupational] [or] [Voluntary Activity] Hepatitis Benefit	35
U-IMC-174-A CW (09/11)	Recuperation Benefit	56
U-IMC-175-A CW (09/11)	Student [Tuition] [and] [Expense] Reimbursement Benefit	38
U-IMC-176-A CW (09/11)	Accelerated Payment Benefit	35
U-IMC-177-A CW (09/11)	Accident Medical Expense Indemnity Benefit	47
U-IMC-178-A AR (09/11)	Complications of Pregnancy Benefit	36

Although some of the forms listed above may not have achieved the minimum readability standards required by your State Insurance Code, we respectfully request approval based on our belief that:

1. the lower score provides a more accurate reflection of the readability of the form(s); and
2. the lower score is warranted by the nature of the particular form(s) or type or class of form(s).

Signature: 

Officer: Lisa Plante

Title: Head of A&H Product Management

Date: October 24, 2011

Statement of Variables for Arkansas

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

Each bracketed benefit or provision will be in or out (in if needed, otherwise omitted). Each bracketed phrase will be in or out. In each instance, the Policy Schedule will be amended to reflect the limits shown for the Benefit. In all instances, references to the **Covered Person** or **You** will be in or out depending on the **Plan** chosen by the **Policyholder**.

ADMINISTRATIVE CHANGE ENDORSEMENT – U-IMC-104-B CW (09/11)

[This endorsement will be used to make the following types of administrative changes to the **Policy** at **Your** request: 1. Policyholder's Name or Address; 2. Addition or deletion of Covered Dependent(s); 3. Addition or deletion of Coverage(s); 4. Increase or decrease in Coverage Amount(s); 5. Addition or deletion of Benefit Riders; 6. Increase or decrease in Benefit Amount(s); or 7. Renewal of the Policy.]	This endorsement will be used to make administrative changes to the Policy.

ADDITIONAL ACCIDENTAL DISMEMBERMENT [AND] [COVERED LOSS OF USE] [AND] [PLEGIA] FOR DEPENDENT CHILDREN BENEFIT - U-IMC-109-A CW (09/11/)

If **You** select a **Plan** covering **Your** eligible **Dependent Child(ren),** and a covered **Dependent Child** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Dismemberment [and] [Covered Loss of Use] [and Plegia] Coverage, **We** will pay [the **Covered Person**][**You**] an additional benefit which will be equal to the benefit amount provided by the Accidental Dismemberment [and] [Covered Loss of Use] [and Plegia] Coverage**.**	[and] [Covered Loss of Use] [and Plegia] will be in or out. [and] [Covered Loss of Use] [and Plegia] will be in or out.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.	[not] will be in or out.

AFTER SCHOOL CARE BENEFIT - U-IMC-123-A CW (09/11)

If [a **Covered Person** selects] [**You** select] [a **Plan** covering [**Dependents**][**Dependent Child(ren)**] and [the **Covered Person**][**You**] or [his or her][**Your**] **Spouse** [**/Domestic Partner**]] suffers a **Covered Injury** resulting in a **Covered Loss** which is payable under the [Accidental Death [and Accidental Dismemberment] Coverage, **We** will reimburse the charges actually incurred by [the **Covered Person**][**You**] for the after school care for each **Dependent Child**, who is [ten (10)] years old or less, up to the amount shown on the Schedule.	[a **Plan** covering [**Dependents**][**Dependent Child(ren)**] and…**Spouse** [**/Domestic Partner**]] will be in or out. If in, [**Dependents**][**Dependent Child(ren)**] will be in or out. [**/Domestic Partner**] will be in or out. [Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Dismemberment]] will be in or out. [ten (10)]. The range will be 4 - 15 The amount of reimbursement will range from $100 - $100,000.
[If [the **Covered Person**] [**You**] and [his or her] [**Your Spouse**][**/Domestic Partner**] both die as a result of the same **Covered Injury**, and **We** pay a[n] [Accidental Death] **Principal Sum** amount on both **Covered Persons**, only the **Policyholder's Principal Sum** will be used to calculate the amount applicable under this benefit.]	This will be in or out. If in, [his or her] will be in or out [**Your Spouse**] will be in or out. [**/Domestic Partner**] will be in or out. [n] will be in or out. [Accidental Death] will be in or out.
This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child(ren)** [is][are] under age [ten (10)] at the time of each payment.	[four (4)]. The range will be 1 – 8 [is][are] will be in or out. [ten (10)]. The range will be 4 – 15
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**	[not] will be in or out.

INFLATION BENEFIT - U-IMC-124-A CW (09/11)

If [a **Covered Person** sustains][**You** sustain] a **Covered Injury** that results in a **Covered Loss** payable under the [Accidental Death [and Accidental Dismemberment]] Coverage, the Inflation Benefit will provide an inflation adjustment to the **Principal Sum**.	[Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out.
The Inflation Benefit is the [**Covered Person's**][**Your**] amount of **Principal Sum**, at the time of claim, multiplied by the product of: 1. the Inflation Benefit Percentage as shown on the Schedule; and 2. one (1) credited year for every two (2) years of continuous coverage under the **Policy** prior to the **Covered Loss**; to a maximum of [ten (10)] multiplied by the injured **Covered Person's** amount of original **Principal Sum**. [(Principal Sum) x (Benefit Percentage x Years of Credited Coverage) = Inflation Benefit amount.]	[ten (10)]. The range will be 1 to 20. These numbers will be inserted.
[If [a **Covered Person** increases][**You** increase] the **Principal Sum**, **We** will apply the Inflation Benefit separately to each additional increase under the **Policy**. Likewise, if [a **Covered Person** decreases][**You** decrease] the **Principal Sum**, **We** will correspondingly reduce any Inflation Benefit that was previously increased.]	This will be in or out.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.	[not] will be in or out.

HIV OCCUPATIONAL ACCIDENT BENEFIT - U-IMC-131-A CW (09/11)

If [the **Covered Person** suffers][**You** suffer] a **Covered Injury** resulting in a **Covered Loss** while performing his or her job related duties, which causes [the **Covered Person**][**You**] to acquire and test positive within [three hundred sixty-five (365)] days of such **Covered Accident** for Human Immunodeficiency Virus (HIV) and/or AIDS and related complex (ARC), **We** will pay an HIV Occupational Accident Benefit. Such HIV Occupational Accident Benefit will be equal to the amount shown on the Schedule. The HIV Occupational Accident Benefit will be paid in [twenty-four (24)] equal monthly installments.	[three hundred sixty-five (365)] The range will be from 30 - 720. [twenty-four (24)] The range will be 2 - 60
If the initial test is negative, and [the **Covered Person**][**You**] subsequently test(s) positive for HIV, AIDS or ARC within [three hundred sixty-five (365)] days of the **Covered Accident**, **We** will begin monthly payments on the first day of the month following receipt of the report indicating positive test results.	[three hundred sixty-five (365)] The range will be from 30 - 720.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**	[not] will be in or out.

[PERMANENT] [TEMPORARY] TOTAL DISABILITY BENEFIT - U-IMC-139-A AR (09/11)

[**PERMANENT**] [**TEMPORARY**] **TOTAL DISABILITY BENEFIT**	[**PERMANENT**] [**TEMPORARY**] will be in or out
If [a **Covered Person**][**You**] suffer[s] a **Covered Injury** resulting in a **Covered Loss** that renders [the **Covered Person**][**You**] [Permanently][Temporarily] **Totally Disabled**, **We** will pay a [Permanent][Temporary] Total Disability Benefit provided that [the **Covered Person** becomes][**You** become] [Permanently][Temporarily] **Totally Disabled** within [three hundred sixty-five (365)] days of the **Covered Injury**; and the [Permanent] [Temporary] **Total Disability** continues for [twelve (12)] consecutive months.	[s] will be in or out. [Permanently] [Temporarily] In all instances, these will be in or out. [three hundred sixty-five (365)] The range will be 90 - 730 [twelve (12)] This will be in if [Permanent] is in; otherwise, it will be omitted. If in, the range will be six 6 - 12
The [monthly] [lump sum] amount payable under this benefit will be equal to the amount shown on the Schedule. [The payments under this benefit will cease at the earliest of the following times: 1. **We** make [sixty 60] payments under this benefit; 2. [The **Covered Person** is][**You** are] no longer [Permanently] [Temporarily] **Totally Disabled**; or 3. [The **Covered Person**][**You**] die[s].	[monthly] [lump sum] will be in or out. This will be in or out. If in, [sixty (60)] the range will be six 6 - 60.
Payments will begin on the on the thirty-first (31st) consecutive day of **Total Disability** and will continue for as long as [the **Covered Person** is][**You** are] **Totally Disabled**, but will not exceed the **Benefit Period** of [sixty (60)] months.]	[sixty (60] the range will be six 6 - 60.
Successive periods of **Total Disability** arising out of the same **Covered Injury** will be considered one **Total Disability** if they are separated by a period of less than [six (6)] months.	[six (6)] The range will be three 3 - 12
For the purposes of this rider only, the following additional definitions apply:	
[**Benefit Period** means the time period that benefits are payable under this benefit subject to any other restrictions or limitations in the **Policy**.]	This will be in or out. If in,
Total Disability (Totally Disabled) means disability that: 1. prevents [a **Covered Person**][**You**] from performing the material and substantial duties of any occupation for which [the **Covered Person** is] [**You** are] qualified by reason of education, training, or experience [or if for a **Covered Person** whom is not employed means that the person is unable to engage any of the usual activities of a person of like age and sex whose health is comparable to that of [the **Covered Person**][**You**]] immediately prior to the **Covered Accident**; and 2. requires the **Continuous Care** and treatment of a **Physician**.	This will be in or out.

If [the **Covered Person** does][**You** do] not adhere to the treatment plan the **Physician** prescribes relating to [his or her][**Your**] disabling condition, [the **Covered Person**][**You**] shall not qualify for the [Permanent][Temporary]Total Disability Benefit. [The **Covered Person**][**You**] shall not qualify for **Total Disability** [if the **Covered Person**][**You**] engage in any activity, such as employment, that results in earned income.	[his or her][**Your**] will be in or out. [Permanent] [Temporary] will be in or out.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.	[not] will be in or out.

CRITICAL BURN BENEFIT - U-IMC-141-A CW (09/11)

If [a **Covered Person** suffers][**You** suffer] a **Covered Injury** that is a **Critical Burn** resulting in a **Covered Loss** as a result of an **Covered Accident, We** will pay a benefit as shown on the Schedule, provided:	
1. [The **Covered Person** receives][**You** receive] [second degree or higher] burns over at least [twenty-five (25%)] of his or her body[; and][.]	[second degree or higher]. The severity of the burn will be inserted. [twenty-five (25%)] the range will be 10% to 80%. [; and] [.] these will be in or out.
2. [within [three hundred sixty-five (365)] days of the **Covered Accident**, [the **Covered Person** has][**You** have] undergone reconstructive surgery to treat the burned areas of the body.]	This will be in or out. If in, [three hundred sixty-five (365)] the range will be 90 - 365 days.
For the purposes of this rider only, **Critical Burn** means cosmetic disfigurement of the surface of a body area due to a **Covered Injury** [that is a full-thickness or third-degree burn,] as determined by a **Physician**. [(A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).]	This will be in or out. This will be in or out.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.	[not] will be in or out.

CONTINUATION OF INSURANCE BENEFIT - U-IMC-147-A CW (09/11)

If **You** [select a **Plan** covering **Your** [**Spouse**[**/Domestic Partner**]] [and] [**Dependent Child(ren)**] and **You** suffer a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death Coverage, provided there are no premium payments in arrears, all coverages under this **Policy** which were in force on the date of the loss will continue with respect to **Your** eligible **Dependents** for [three hundred sixty-five (365)] days after the date of loss with no additional premium payments.	[select a **Plan** covering **Your** [**Spouse**[/**Domestic Partner**]] This will be in or out. If in, [**Spouse**[/**Domestic Partner**] will be in or out. [/**Domestic Partner**] will be in or out. [and] [**Dependent Child(ren)**] will be in or out. [three hundred sixty-five (365)] the range will be 90 – 365.
For the purposed of this rider only, insurance for eligible **Dependents** terminates on the earliest of: 1. [three hundred sixty-five (365) days] after the date of **Covered Loss**; 2. the first premium due date after the **Dependent** no longer qualifies as a **Covered Person**; 3. [for the covered **Spouse**[**/Domestic Partner**], the date the covered **Spouse**[**/Domestic Partner**] reaches age [seventy (70)].]	[three hundred sixty-five (365)] the range will be 90 -365. This will be in or out. If in, [/**Domestic Partner**] will be in or out. [seventy (70)] The range will be 50 - 85.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.	[not] will be in or out.

DAY CARE BENEFIT - U-IMC-148-A CW (09/11)

If **You** [select a **Plan** covering **Your Dependents** and **Your** covered **Spouse** [**/Domestic Partner**]] suffers a **Covered Injury** resulting in a **Covered Loss,** which is payable under the Accidental Death Coverage, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each covered **Dependent Child** if:	This will be in or out. If in, [**/Domestic Partner**]] will be in or out.
1. on the date of the **Covered Accident**, the covered **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and	[ninety (90)]. The range will be 30 to 365 days.
2. the covered **Dependent Child** is under age [thirteen (13)].	[thirteen (13)] The range will be 2-18.
The **Day Care Benefit** will be equal to the lesser of:	
1. the actual cost of the child care;	
2. [three (3%)] of the **Principal Sum** of the [**Covered Person**][**Policyholder**] who suffered the **Covered Loss**; or	[three (3%)] The range will be 1% - 10%
3. [$3,000].	[$3,000] The range will be $500 - $30,000
If both **You** and **Your** covered **Spouse** [**/Domestic Partner**] suffer a simultaneous **Covered Loss** which is payable under the Accidental Death Benefit, the Day Care Benefit will be based on the **Your Principal Sum**.	[/**Domestic Partner**] will be in or out.
The Day Care Benefit will be paid annually for [four (4)] consecutive years if:	[four (4)]. The range will be 1 – 10
1. the covered **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and	[thirteen (13)] the range will be 2 – 18
2. proof, acceptable to **Us**, is received by **Us** that verifies that the covered **Dependent Child** remains enrolled in an **Accredited Child Care Facility**.	
[The maximum amount payable under this benefit is [$4,000].	[$4,000] the range will be $500 - $30,000
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**	[not] will be in or out.

HEARING AID OR PROSTHETIC APPLIANCE BENEFIT – U-IMC-149-A CW (09/11)

If [a **Covered Person** suffers][**You** suffer] a **Covered Injury** resulting in a **Covered Loss,** which is payable under the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Coverage, **We** will pay an additional benefit provided:	[and Covered Loss of Use] will be in or out. [and Plegia] will be in or out.
1. [the **Covered Person** is] [**You** are] required to use a Hearing Aid or **Prosthetic Appliance**;	
2. the **Covered Injury** that caused the payment of the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Coverage is the same **Covered Injury** that requires [the **Covered Person**][**You**] to use the Hearing Aid or **Prosthetic Appliance**; and	[and Covered Loss of Use] will be in or out. [and Plegia] will be in or out.
3. the Hearing Aid **or Prosthetic Appliance** was required within [three hundred sixty-five (365)] days of the **Covered Injury**.	[three hundred sixty-five (365)] The range will be 90 - 730 days.
This benefit will not be paid unless:	
1. the Hearing Aid or **Prosthetic Appliance** was prescribed by a **Physician** that is not **Related** to [the **Covered Person's**] [**Your**] **Spouse**[/**Domestic Partner**], or **Dependent Child**, or relative; and	[/**Domestic Partner**] will be in or out.
The maximum amount payable under all provisions of this benefit combined will be the lesser of [ten (10%)] of the [**Principal Sum** of the **Covered Person**][**Your Principal Sum**] or [$10,000].	[ten (10%)]. The range will be 5% - 50%. [$10,000]. The range will be $1,000- $50,000.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.	[not] will be in or out.

EMERGENCY [TRANSPORTATION] [AND] [TREATMENT] [AND] HOSPITAL CASH BENEFIT
U-IMC-153-A AR (09/11)

EMERGENCY [TRANSPORTATION] [AND] [TREATMENT] [AND] HOSPITAL CASH BENEFIT	[**TRANSPORTATION**] [**AND**] [**TREATMENT**] [**AND**] will be in or out.
[EMERGENCY TRANSPORTATION BENEFIT If [a **Covered Person** suffers][**You** suffer] a **Covered Injury** that requires **Emergency Treatment** within [12, 24, 48] hours of the date of the **Covered Accident** that caused the **Covered Injury** and it is determined that it is **Medically Necessary** that [the **Covered Person**][**You**] be transported to a **Hospital** or a **Satellite Emergency Center** by **Ambulance**, the **Company** will pay 100% of the Emergency Transportation Maximum Amount shown in the Schedule. Only one Emergency Transportation Benefit is payable for any one **Covered Accident** [per **Covered Person**][to **You**]. [The maximum number of Emergency Transportation Benefits payable per calendar year [per **Covered Person**][to **You**] regardless of the number of **Covered Accidents** incurred, is shown in the Schedule.]]	This will be in or out. If in, [12, 24, 48] hours. One of these three choices will be inserted. This will be in or out.
[EMERGENCY TREATMENT BENEFIT If [a **Covered Person** suffers][**You** suffer] a **Covered Injury** that, within [24,48,72] hours of the date of the **Covered Accident** that caused the **Covered Injury,** requires [the **Covered Person**][**You**] to receive **Medically Necessary Emergency Treatment** in a **Hospital** emergency room or a **Satellite Emergency Center**, the **Company** will pay 100% [of the applicable] Emergency Treatment Benefit Maximum Amount shown in the Schedule. Only one Emergency Treatment Benefit[, the largest,] is payable for any one **Covered Accident** [per **Covered Person**][to **You**]. [The maximum number of Emergency Treatment Benefits payable per calendar year [per **Covered Person**][to **You**] regardless of the number of **Covered Accidents** incurred, is shown in the Schedule.]]	This will be in or out. If in, [24, 48, 72] hours. One of these three choices will be inserted. [of the applicable] will be in or out. [, the largest,] will be in or out. This will be in or out.
[If [a **Covered Person** incurs][**You** incur] expenses for both Emergency Transportation and **Emergency Treatment** due to the same **Covered Accident**, only one amount, the highest, will be paid.] [A maximum of [two (2)] Emergency Transportation Benefits or **Emergency Treatment** Benefits are payable [per **Covered Person**][to **You**] per calendar year regardless of the number of **Covered Accidents** incurred in that same calendar year.]	This will be in or out. If in, This will be in or out. If in, [two (2)] the range will be 1 – 10.
EMERGENCY HOSPITAL CASH If [a **Covered Person** is][**You** are] **Hospital Confined** due to **Covered Injury**, **We** will pay a daily allowance according to the actual days in **Hospital** up to the maximum benefit of [thirty (30)] days. [**We** will not pay any claim for the first three (3) calendar days of each emergency hospital cash within the United States.]	[thirty (30)] The range will be 1 to 90. This will be in or out.

For the purposes of this rider only, the following additional definitions apply:	
[**Ambulance** means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded. **Ambulance** does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]	This will be in or out.
Hospital Confinement (Hospital Confined) means admission to a **Hospital** as an inpatient for at least [twenty-four (24)] consecutive hours by a **Physician** for a **Covered Injury**. A **Hospital** stay that does not result in charges to [the **Covered Person**][**You**] is not a **Hospital Confinement** under this rider unless there is no charge because the **Hospital** is a United States government facility.	[twenty-four (24)] The range will be 12 to 96.
Medically Necessary means an [**Emergency Treatment**] [or] [Emergency Transportation] is: 1. essential for the diagnosis, treatment and care of the Injury; 2. meets generally accepted standards of medical practice; [or] 3. is ordered by a **Physician** and performed under the **Physician's** care, supervision or order[; or 4. [with regard to Emergency Transportation, is subsequently authorized by a **Physician** as appropriate due to the nature of the **Covered Injury**].	[**Emergency Treatment**] [or] [Emergency Transportation] will be in or out. [or] will be in or out. [or] will be in or out. [with regard to emergency Transportation…] will be in or out.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**	[not] will be in or out.

TRAUMATIC BRAIN INJURY BENEFIT - U-IMC-161-A AR (09/11)

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** that results in a **Traumatic Brain Injury** within [ninety (90)] days of the date of the **Covered Accident** which:	[ninety (90)] The range will be 60 – 365 days.
1. requires [that a **Covered Person**][**You** to] be **Hospitalized** for at least [seven (7)] days during the first [ninety (90)] days following the **Covered Accident**; and	[seven (7)]. The range will be 7 -14 days [ninety (90)]. The range will be 60 – 365 days.
2. continues for [nine (9)] consecutive months,	[nine (9)]. The range will be 6 -12 consecutive months.
We will pay a **Traumatic Brain Injury** Benefit.	
The **Traumatic Brain Injury** Benefit is equal to [the **Principal Sum** of the **Covered Person** that sustained the **Covered Injury**][**Your Principal Sum** provided that **You** sustained the **Covered Injury**].	This will be in or out.
[**We** will not pay this benefit if a benefit is payable to [a **Covered Person**][**You**] for Loss of Life under the Accidental Death [and Accidental Dismemberment] Coverage].	This will be in or out. If in, [and Accidental Dismemberment] will be in or out.
Traumatic Brain Injury means physical damage to the brain which is certified by a **Physician** to be: (1) permanent, complete and irreversible; and (2) prevents the injured person from performing all the substantial and material functions and activities of a person of like age and gender in good health.	
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**	[not] will be in or out.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT - U-IMC-171-A CW (09/11)

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Dismemberment [and Covered Loss of Use][and Plegia] coverage, **We** will pay an additional benefit for home alterations and/or vehicle modifications, provided:	[and Covered Loss of Use] will be in or out. [and Plegia] will be in or out.
1. [the **Covered Person** is] [**You** are] required to use a wheelchair to be ambulatory on a permanent basis; and	
2. the **Covered Injury** that caused the payment of the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Coverage is the same **Covered Injury** that requires [the **Covered Person**] [**You**] to use the wheelchair.	[and Covered Loss of Use] will be in or out. [and Plegia] will be in or out.
The maximum amount payable under all provisions of this benefit combined will be the lesser of [ten (10%)] of [the **Principal Sum** of the **Covered Person** that sustained the **Covered Injury**][**Your Principal Sum**] or [$10,000].	[ten (10%)]. The range will be 1% - 50%. [$10,000]. The range will be $1,000- $50,000.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**	[not] will be in or out.

NATURAL DISASTER BENEFIT - U-IMC-172-A CW (09/11)

If [a **Covered Person**] [**You**] suffer[s] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death [or Accidental Dismemberment] [and Covered Loss of Use] [and Plegia] Coverage, **We** will pay a benefit equal to the lesser of [ten (10%)] of the [**Covered Person's**][**Your**] **Principal Sum** or [$10,000], provided [the **Covered Person**] [**You**] suffer[s] the **Covered Injury** as a direct result of a **Natural Disaster**. This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.	[s] will be in or out. [or Accidental Dismemberment] will be in or out. [and Covered Loss of Use] will be in or out. [and Plegia] will be in or out. [ten (10%)] the range will be 10% -100% [$10,000] the range will be [$500 - $50,000] [s] will be in or out. [not] will be in or out.

[OCCUPATIONAL] [OR] [VOLUNTEER ACTIVITY] HEPATITIS BENEFIT - U-IMC-173-A CW (09/11)

[**OCCUPATIONAL**] [**OR**] [**VOLUNTEER ACTIVITY**] **HEPATITIS BENEFIT**	[**OCCUPATIONAL**] [**OR**] [**VOLUNTEER ACTIVITY**] These will be in or out.
If [a **Covered Person**][**You**] test[s] positive for **Hepatitis** within [three hundred sixty-five (365)] days of the date of an [**Occupational Incident**] [or] [**Volunteer Activity**], **We** will pay the benefit amount to [the **Covered Person**] shown in the Schedule][**You**]. The benefit is payable if, within seventy-two (72) hours of the [**Occupational Incident**] [or] [**Volunteer Activities**], the [**Covered Person**][**You**]:	[s] will be in or out. [three hundred sixty-five (365)] days. The range will be 30 - 730. [**Occupational Incident**] [or] [**Volunteer Activity**] these will be in or out. [**Occupational Incident**] [or] [**Volunteer Activity**] these will be in or out.
1. report[s] the [**Occupational Incident**] [or] [**Volunteer Activity**] to **Us** [and the **Policyholder**] in writing; and 2. undergoes a Food and Drug Administration (FDA) approved preliminary screening test for **Hepatitis** which indicates negativity with respect to the presence of any antibodies or antigens to such disease.	[**Occupational Incident**] [or] [**Volunteer Activity**] these will be in or out. [and the **Policyholder**] will be in or out.
The benefit is payable monthly, starting on the last day of the month which immediately follows the month the [**Covered Person**][**You**] tests positive for **Hepatitis**, for [one hundred twenty-seven (127) consecutive months] or until: 1. the date the [**Covered Person**] [**You**] die(s); or 2. the date the [**Covered Person**] [**You**] recovers from **Hepatitis**, whichever occurs first.	[one hundred twenty-seven (127)] The range will be 1 - 180
If the [**Covered Person**] [**You**] test(s) positive for **Hepatitis** as a result of the same [**Occupational Incident**] [or] [**Volunteer Activity**], only one benefit amount, the largest, will be paid. **We** will not pay for any expenses incurred for testing.	[**Occupational Incident**] [or] [**Volunteer Activity**] these will be in or out.
For purposes of this rider only, the following additional definitions apply:	
Hepatitis means inflammation of the liver caused by a virus or a toxin. **Hepatitis** includes Hepatitis [A], B, C, D and E.	[A] will be in or out.
[**Occupational Incident(s),** means a **Covered Accident** resulting in exposure to **Hepatitis** which occurs while the [**Covered Person**] [**You**] is performing occupational services. The exposure must be either: 1. cutaneous through abraded skin; 2. percutaneous; or 3. mucocutaneous.]	[**Occupational Incident(s)**] will be in or out.
[**Volunteer Activity** (**Volunteer Activities**) means a **Covered Accident** resulting in exposure to **Hepatitis** which occurs while the [**Covered Person**] [**You**] is	This will be in or out.

performing services as a volunteer. The exposure must be either: 1. cutaneous through abraded skin; 2. percutaneous; or 3. mucocutaneous.]	
This rider only provides benefits for [**Occupational Incidents**] [or] [**Volunteer Activity**] as defined above.	[**Occupational Incident**] [or] [**Volunteer Activity**] these will be in or out.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**	[not] will be in or out.

RECUPERATION BENEFIT - U-IMC-174-A CW (09/11)

If [a **Covered Person**][**You**] suffer[s] a **Covered Injury** resulting in a **Covered Loss** and [the **Covered Person** is][**You** are] eligible to receive benefits payable under the [In-Hospital Indemnity Benefit] of the **Policy**, **We** will pay an additional Recuperation Benefit.	[s] will be in or out. [In-Hospital Indemnity Benefit] This is to be replaced with other benefits that include a hospital confinement.
The Recuperation Benefit is equal to the amount shown on the Schedule and will be paid for the same [period of time as the][number of days as was actually paid for the] [In-Hospital Indemnity Benefit].	[period of time as the] [number of days as was actually paid for the] one of these will be included and the range will vary from $25 to $1,000 per day per **Covered Person** consistent with the benefit to which is inserted. [In-Hospital Indemnity Benefit] This is to be replaced with other benefits that include a **Hospital Confinement,** as defined within those associated benefit riders.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.	[not] will be in or out.

STUDENT [TUITION] [AND] [EXPENSE] REIMBURSEMENT BENEFIT U-IMC-175-A CW (09/11)

STUDENT [**TUITION**] [**AND**] [**EXPENSE**] **REIMBURSEMENT BENEFIT**	[**TUITION**] [**AND**] [**EXPENSE**] will be in or out.
[Student Loan Reimbursement If [a **Covered Person** is][**You** are] a **Tuition Payor** and suffer[s] a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Coverage, **We** will pay [the **Covered Person's**][**Your**] outstanding loan balance incurred **Student Tuition** as of date of the **Covered Loss** and owed to a financial institution or federal government for **Academic Studies.** The most **We** will pay is up to the benefit amount shown on the Schedule.]	This will be in or out. If in: [s] will be in or out. [Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out. [Critical Illness] will be in or out. The benefit amount will range from $100 per **Covered Person** per outstanding loan balance to $100,000 for all **Covered Person's** outstanding loan balances in the aggregate.
[Tuition Reimbursement If [a **Covered Person** is][**You** are] enrolled in **Academic Studies** and suffer[s] a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]] [Critical Illness] Coverage and which [prevents the injured **Covered Person**][the injury prevents **You**] from continuing to participate in **Academic Studies**, **We** will pay a **Tuition Expense** benefit as shown on the Schedule.]	This will be in or out. If in: [Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out. [Critical Illness] will be in or out. The **Tuition Expense** amount will range from $100 per **Covered Person** to $500,000 for all **Covered Persons** in the aggregate.
[Student Tuition and Tuition Expenses If [a **Covered Person** that is][**You** are] a **Tuition Payor** and suffer[s] a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Coverage and there is an obligation to pay **Student Tuition** [to the **Policyholder**] on behalf of the **Covered Person**, **We** will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The benefit amount will increase annually by the lesser of the actual **Student Tuition** and **Tuition Expense**, or [(ten 10%)].]	This will be in or out. If in, [s] this will be in or out. [Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out. [Critical Illness] will be in or out. [to the **Policyholder**] will be in or out. The annual benefit will range from $100 to $50,000 per **Covered Person** and up to $200,000 in the aggregate for all **Covered Persons**. The maximum number of payments will range from 1 to 16 per **Covered Person**. [ten (10%)] the benefit increase will vary from 0 to 100%.
[Student Expenses If [a **Covered Person** that is][**You** are] a **Tuition Payor** and suffer(s) a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Coverage and prevents the **Tuition Payor** from continuing to pay the **Student Expenses** incurred by the **Covered Person** for **Academic Studies**, **We** will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The benefit amount will increase annually by the lesser of the actual **Student Expenses** or [ten (10%)].]	This will be in or out. If in: [Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Dismemberment] will be in or out. [Critical Illness] will be in or out. The annual benefit will range from $100 to $50,000 per **Covered Person** and up to $200,000 in the aggregate for all **Covered Persons**. The maximum number of

	payments will range from 1 to 16 per **Covered Person**. [ten (10%)]The range will vary from 0 to 100%.
Payment Of Claims. Unless otherwise requested by **You**, the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Coverage will be paid directly to the [**Covered Person**] [or beneficiary] [or **Policyholder**] up to the total amount of actual [**Tuition Expense**] [and] [**Student Expenses**] due from the **Tuition Payor**. Any payment made in good faith will release **Us** from any liability to the extent of the payment.	[Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out. [Critical Illness] will be in or out. [**Covered Person**] [or beneficiary] [or **Policyholder**] each will be in or out. [**Tuition Expense**] [and] [**Student Expenses**] each will be in or out.
For the purposes of this rider only, the following additional definitions apply:	
Academic Studies means the full-time attendance at an educational institution or school for the purpose of advancing education and for which the **Tuition Payor** incurred **Student Tuition** [and room and board (if supplied by the university, college or trade school)] to attend.	This will be in or out.
[**Covered Person** means any person who has insurance under the terms of this **Policy**. It includes **You** [,and **Your Spouse**[**/Domestic Partner**] and/or **Dependent Child(ren)** if a **Plan** covering the **Spouse** [**/Domestic Partner**] and/or **Dependent Child(ren)** is selected. **Covered Person** also includes the **Spouse**[**/Domestic Partner**] and/or **Dependent Child(ren)** designated by **You** as enrolled in **Academic Studies** regardless of the **Plan** chosen by **You**.]	This will be in or out. If in, This will be in or out. If in, [**/Domestic Partner**] will be in or out. [**/Domestic Partner**] will be in or out. [**/Domestic Partner**] will be in or out.
[For the purposes of this rider only, the following additional exclusions apply.	This will be in or out. If in,
Coverage does not apply to: 1. [Expenses previously reimbursed to the **Tuition Payor** or **Covered Person** through any employment tuition reimbursement program;] 2. [Academic Scholarships provided to the **Covered Person**.] 3. [Athletic Scholarships provided to the **Covered Person**.] 4. [Student loans made to or on behalf of the **Tuition Payor** or the **Covered Person**.]]	Exclusions 1-4 will be in or out.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.	[not] will be in or out.

ACCELERATED PAYMENT BENEFIT - U-IMC-176-A CW (09/11)

In the event that [a **Covered Person** is][**You** are] **Terminally Injured**, [the **Covered Person**] [**You**] may be eligible to receive an Accelerated Benefit. **We** will pay the applicable Accelerated Benefit amount as shown below, provided the **Terminally Injured Covered Person**:	This will be in or out.
1. is covered under the **Policy**; 2. is under age [60-70]; and 3. provides Proof of Loss to **Us** of such **Terminal Injury**.	[60 - 70] either 60 or 70 will be inserted.
[The **Covered Person**][**You**] may request a minimum Accelerated Benefit amount of [$3,000, and a maximum of $100,000]. However, in no event will the Accelerated Benefit Amount exceed [thirty (30%)] of the **Terminally Injured** [**Covered Person's**][**Your**] **Principal Sum** of Accidental Death Coverage. [This option may be exercised only once for [each **Covered Person**][**You**].] The Accelerated Benefit payment will be made to [the **Covered Person**][**You**] now instead of [the **Covered Person's**][**Your**] beneficiary upon death.	[$3,000 and a maximum of $100,000]. The range will be $500 and a maximum amount of $500,000. [thirty (30%)] the range will be 10% - 50%. This will be in or out.
[For example, if [the **Covered Person** is][**You** are] covered for an Accidental Death Coverage amount under the **Policy** of [$100,000] and **Terminally Injured**, [the **Covered Person**] [**You**] can request any portion of the amount of Accidental Death Coverage from $3,000 to $30,000 to be paid now instead of to [the **Covered Person's**] [**Your**] beneficiary upon death. However, if [the **Covered Person**][**You**] decide[s] to request only [$3,000] now, [the **Covered Person**][**You**] cannot request the additional [$27,000] in the future]. Any benefits received under this rider may be taxable. [The **Covered Person**][**You**] should consult a personal tax advisor for further information.	This will be in or out. If in, the ranges will be consistent with that above.
Disabled means that due to the **Terminal Injury** the [**Covered Person** is] [**You** are]: 1. unable to perform the material and substantial duties of any occupation to which the [**Covered Person** is] [**You** are] suited by education, training, or experience[; or 2. with respect to a **Spouse**[/**Domestic Partner**] who is unemployed, his or her ability to engage in the normal and customary activities of a person of like age and gender in good health].	This will be in or out. If in: [/**Domestic Partner**] will be in or out
Terminal Injury or Terminally Injured means the **Covered Injury** suffered by [the **Covered Person**][**You**] which resulted in [the **Covered Person**][**You**] having a life expectancy of [nine (9)] months or less.	[nine (9)] The range will be 6 - 12 months.
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy.**	[not] will be in or out.

[Emergency Room Treatment **We** will pay [$500] once per [forty-eight (48)] hour period and once per **Covered Accident**, [per **Covered Person**][to **You**] when [that **Covered Person** receives][**You** receive] emergency room treatment for **Injuries** sustained in a **Covered Accident**. This benefit is for treatment by a **Physician** or treatment received in a **Hospital** emergency room. Treatment must be received within [forty-eight (48)] hours of the **Accident** for benefits to be payable.]	This will be in or out. If in, [$500] the range will be $25 - $5,000. [forty-eight (48)] the range will be 12-96. [forty-eight (48)] the range will be 12 – 96
[X-Rays Related to an Accident **We** will pay [$500] once per **Covered Accident**, [per **Covered Person**][to **You**] when [a **Covered Person** requires][**You** require] an X-ray while receiving emergency room treatment in a **Hospital** for **Injuries** sustained in a **Covered Accident**. This benefit is not for X-rays received in a **Physician's** office. [The X-Ray Benefit is not for exams listed in the Diagnostic Testing & Exams Benefit.]]	This will be in or out. If in, [$500] The range will be $25 - $1,000 This will be in or out.
[Emergency Room Follow Up Treatment **We** will pay [$500] for one treatment per day, up to a maximum of [three (3)] treatments per **Covered Accident** for [each **Covered Person**][**You**] when [that **Covered Person** receives][**You** receive] emergency room treatment for **Injuries** sustained in a **Covered Accident** and later requires additional treatment in addition to the original emergency room treatment administered in the first [48] hours following the **Covered Accident**. The subsequent treatment must begin within [thirty (30)] days of the **Covered Accident** or discharge from the **Hospital**, the **Hospital Confinement** for which must be causally related to the same **Covered Accident** for which the subsequent treatment is being sought. Treatments must be furnished by a **Physician** in a **Physician's** office or in a **Hospital** on an outpatient basis. This Benefit is not payable for days wherein additional emergency room treatment benefits are payable.]	This will be in or out. If in, [$500] the range will be $25 - $1,000 [three (3)] the range will be 2 - 6 [forty-eight (48)] the range will be 12 – 96 [thirty (30)] the range will be 10 - 90
[Accident Hospitalization **We** will pay [$500] once per period of **Hospital Confinement** or [$500] once when [a **Covered Person** is][**You** are] admitted directly to an **Intensive Care Unit** [two (2)] time(s) per calendar year [per **Covered Person**][to **You**] when [that **Covered Person** is][**You** are] admitted for a **Hospital Confinement** of at least [eighteen (18)] hours for treatment of **Injuries** sustained in a **Covered Accident** or if [a **Covered Person** is][**You** are] admitted directly to an **Intensive Care Unit** of a **Hospital** for treatment of **Injuries** sustained in a **Covered Accident**. **Hospital Confinements** must start within [sixty (60)] days of the **Covered Accident**.]	This will be in or out. If in, [$500] the range will be $500 - $10,000 [$500] the range will be $500 - $10,000 [two (2)] times (s) the range will be 1 -10 [eighteen (18)] the range will be 12 – 24 [sixty (60)] the range will be 10 – 90
[Specific **Principal Sum** Accidental Injuries **We** will pay [$5,000] for the following **Covered Injuries**:	This will be in or out. If in, [$5,000] the range will be $25 - $10,000

[1. Dislocation Benefit **Dislocation** (reduced under general anesthesia): **We** will pay for no more than [two (2)] **Dislocations** per **Covered Accident** [per **Covered Person**][to **You**].	This will be in or out. If in, [two (2)] the range will be [1 – 10]
Benefit: Joint Area **Open Reduction** **Closed Reduction** A. – J. [$2,500] [$500]]	The ranges will be: Joint Area **Open Reduction** **Closed Reduction** A. – J. [$25 - $5,000] [$25 -$1,500]
If a **Dislocation** is reduced with local anesthesia, or no anesthesia by a **Physician** or a Physician Assistant, **We** will pay [fifty (50%)] percent of the amount shown for the closed **Reduction Dislocation**.]	[fifty (50%)] the range will be 25% – 100%]
[2. Burn Benefit For burns arising out of a **Covered Accident** and treated by a **Physician** within [forty-eight (48)] hours after that **Covered Accident**, **We** will pay the following:	This will be in or out. If in, [forty eight (48)] the range will be 12 – 96
Benefit: Body Surface Area 2nd Degree 3rd degree A. Less than 50 sq. cm. [2,500] [$5,000] B. > than 100 but < 150 sq. cm [2,500] [$5,000] C. > than 150 but < 200 sq. cm [2,500] [$5,000] D. > than 200 but < 250 sq. cm [2,500] [$5,000] E. > than 250 but < 300 sq. cm [2,500] [$5,000] F. > than 300 sq cm [2,500] [$5,000]]	The ranges will be: Body Surface Area 2nd Degree 3rd degree A. Less than 50 sq. cm. [$25-5,000] [$100-10,000] B. > than 100 but < 150 sq. cm [$25-5,000] [$100-10,000] C. > than 150 but < 200 sq. cm [$25-5,000] [$100-10,000] D. > than 200 but < 250 sq. cm [$25-5,000] [$100-10,000] E. > than 250 but < 300 sq. cm [$25-5,000] [$100-10,000] F. > than 300 sq cm [$25-5,000] [$100-10,000]
[3. Skin Grafts If [a **Covered Person** receives][**You** receive] up to [five (5)] skin graft(s) for a burn from a **Covered Accident**, **We** will pay a total of [seventy-five(75%)] of the Burns Benefit amount **We** paid for the burn involved in addition to the amount paid for the Burn Benefit.]	This will be in or out. If in, [five (5)] the range will be 1 -10 [seventy-five (75%)] the range will be 10% - 100%
[4. Eye Injuries If [a **Covered Person sustains**][**You** sustain] an **Injury** to an eye as a results of a **Covered Accident**, **We** will pay the following: a. Surgical repair [$1,000] b. Removal of foreign body by a **Physician** [$250].]	This will be in or out. If in, [$1,000] the range will be $25 – $2,500 [$250] the range will be $25 - $500
[5. Lacerations If [the **Covered Person** sustains][**You** sustain] a laceration as a result of a **Covered Accident**, provided the laceration is repaired within [forty-eight (48)] hours after the **Covered Accident** and repaired under the attendance of a **Physician, We** will pay the following:	This will be in or out. If in, [forty-eight (48)] the range will be 12-96
Benefit: Laceration Benefit Amount A. Laceration(s) not requiring . . . [$500] B. Laceration(s) less than 5 cm. . . . [$500] C. Lacerations at least 5 cm. . . . [$500]	If in, the ranges will be Benefit: Laceration Benefit amount A. Laceration(s) not requiring . . . [$25 - 1,000] B. Laceration(s) less than 5 cm. . . . [$25 - 1,500] C. Lacerations at least 5 cm. . . . [$25 - 2,500]

D. Lacerations over 15 cm . . . . [$500]]	D. Lacerations over 15 cm . . . . [$25 - 5,000]
[6. Fractures **We** will pay for no more than [five (5)] **Fractures** per **Covered Accident**, [per **Covered Person**][to **You**]. In the event of multiple fractures (more than [three (3)]) sustained by the same **Covered Person**, **We** will pay for the larger **Fracture** amounts. However, **We** will pay [fifty (50%)] percent of the benefit amount shown for the closed **Reduction** for **Chip Fractures** and other **Fractures** not reduced by Open or Closed **Reduction**.	This will be in or out. If in, [five (5)] the range will be 1 -10 [three (3)] the range will be 2 – 10 [fifty (50%)] the range will be 10% -100%
Benefit:	If in,
Fracture Area **Open Reduction** **Closed Reduction** A. – Q. [$15,000] [$7,500] R. Finger [$2,500] [$1,000] S. Coccyx [$10,000] [$7,500] T. Toe [$2,500] [$1,000] U. Vertebral [$10,000] [$7,500] V. Skull (i) Depressed [$10,000] [$7,500] (ii) Simple [$10,000] [$7,500]]	Fracture Area **Open Reduction** **Closed Reduction** A. – Q. [$100- $25,000] [$100 -$15,000] R. Finger [$100 – $5,000] [$100 – $2,500] S. Coccyx [$100 – $25,000] [$100 – $15,000] T. Toe [$100 – $5,000] [$100 – $2,500] U Vertebral [$100 – $25,000] [$100 – $15,000] V. Skull (i) Depressed [$100-$25,000] [$100-$15,000] (ii) Simple [$100-$25,000] [$100 -$15,000]
[7. Concussion: If [the **Covered Person** sustains][**You** sustain] a concussion as a result of a **Covered Accident**, **We** will pay [$1,000] for each concussion for each **Covered Person**.]	This will be in or out. If in, [$1,000] the range will be $50 – $1,500
[8. Emergency Dental Procedure: If [the **Covered Person** sustains][**You** sustain] a **Covered Injury** as a result of a **Covered Accident** requiring emergency dental work, **We** will pay the following benefits: a. Broken tooth repaired with crown [$750] b. Broken tooth resulting in extraction [$750]	This will be in or out. If in, a. [$750] the range will be $75 – $1,500 b. [$750] the range will be $25 – $1,500
Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. **We** will pay for no more than [two (2)] Emergency Dental Procedure benefit(s) per **Covered Accident**, [per **Covered Person**][to **You**].]	[two (2)] the range will be 1 – 5
[9. Specified Surgical Procedures Arising from a Covered Accident: If [the **Covered Person** sustains][**You** sustain] a **Covered Injury** as a result of a **Covered Accident** and one of the specified surgical procedures is required, such surgical procedure must be performed within [one (1)] year(s) of the **Covered Accident**. [Two (2) or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, **We** will pay for the most expensive procedure.	This will be in or out. If in, [one (1)] the range will be 1 - 3 This will be in or out.
Benefit: Surgical Procedure Benefit Amount	If in, the ranges will be:

A. Arthroscopy without surgical repair [$5,000] B. Open abdominal [$5,000] C. cranial [$5,000] D. hernia [$5,000] E. Thoracic surgery [$5,000] F. Repair of: [$5,000] i. Tendons and/or ligaments ii. Torn rotator cuffs iii. Ruptured discs iv. Torn knee cartilages]	[$5,000] the range will be $25 - 10,000 [$5,000] the range will be $25 - 10,000 [$5,000] the range will be $25 - 10,000 [$5,000] the range will be $25 - 10,000 [$5,000] the range will be $25 - 10,000 [$5,000] the range will be $25 - 10,000
[10. Non-Specified Surgical Procedures Arising from a Covered Accident: If [a **Covered Person** sustains][**You** sustain] a **Covered Injury** as a result of a **Covered Accident** and a non-specified surgical procedure is required, such surgical procedure must be performed within [one (1)] year of **Covered Accident**. [Two (2) or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, **We** will pay for the most expensive procedure. **We** will pay for the following:	This will be in or out. If in, [one (1)] the range will be 1-3 This will be in or out.
a. Miscellaneous surgery with general anesthesia [$2,500]	a. [$2,500] the range will be $25 – $2,500
b. Other miscellaneous surgery with conscious sedation [$2,500]]	b. [$2,500] the range will be $25 – $2,500
[Diagnostic Testing & Exams Benefit **We** will pay [$2,500] [five (5)] time(s) per calendar year, [per **Covered Person**][to **You**] when a [**Covered Person** requires][**You** require] one of the following exams for **Injuries** sustained in **Covered Accident** and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a Hospital or a Physician's office. [Exams listed in the Diagnostic Testing & Exams Benefit are not covered under the X-Ray Related to an **Accident** Benefit.]]	This will be in or out. If in, [$2,500] the range will be $25 – 45,000 [five (5)] the range will be 1 – 10 This will be in or out.
[Pain Management **We** will pay [$2,500] no more than [five (5)] time(s) per **Covered Accident**, [per **Covered Person**][to **You**] when [a **Covered Person** is][**You** are] prescribed, receives, and incurs a charge for an epidural or other similar treatment administered for pain management in a **Hospital** or a **Physician's** office for **Injuries** sustained in a **Covered Accident**. This benefit is not for an epidural or other similar treatment administered during a surgical procedure [or for pain management associated with pregnancy].]	This will be in or out. If in, [$2,500] the range will be $25 – $5,000. [five (5)] the range will be 1 – 10 This will be in or out.
[Physical Therapy and Rehabilitation **We** will pay [$250] per treatment for [two (2)] treatment(s) per day, up to a maximum of [five (5)] treatment(s) per **Covered Accident**, [per **Covered Person**][to **You**] when	This will be in or out. If in, [$250] the range will be $25 - $500 [two (2)] either 1 or 2 will be inserted. [five (5)] the range will be 1 – 10

[a **Covered Person** receives][**You** receive] emergency treatment for **Injuries** sustained in a **Covered Accident** and later a **Physician** advises [the **Covered Person**][**You**] to seek treatment from a licensed **Physical Therapist**. Physical therapy must be for **Injuries** sustained in a **Covered Accident** and must start within [thirty (30)] days of the **Covered Accident** or discharge from the **Hospital**. The treatment must take place within [six (6)] month(s) after the **Covered Accident**. [The Physical Therapy Benefit is not payable on the same day that the Subsequent Emergency Room Treatment Benefit is paid.]]	[thirty (30)] the range will be 10 – 90 [six (6)] the range will be 1 – 12 This will be in or out.
[Durable Medical Equipment and Prosthetic Appliance **We** will pay [$5,000] once per **Covered Accident**, [per **Covered Person**][for **You**] when [a **Covered Person** receives][**You** receive] **Durable Medical Equipment**, prescribed by a **Physician**, as an aid in personal locomotion for **Injuries** sustained in a **Covered Accident**. Benefits are for the following types of equipment: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches. **We** will pay [$5,000] once per **Covered Accident** [per **Covered Person**][to **You**] when [a **Covered Person** require][**You** require] use of a **Prosthetic Appliance** as a result of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to provide a benefit for the repair or replacement of **Prosthetic Appliance** already prescribed for the **Covered Person**, hearing aids, wigs, or dental aids, including false teeth.]	This will be in or out. If in, [$5,000] the range will be $25 – $10,000 [$5,000] the range will be $25 – $10,000
[Blood, Plasma, and or Platelets **We** will pay [$2,500] once per **Covered Accident** per [per **Covered Person**][to **You**] when [that **Covered Person** receives][**You** receive] blood, plasma, and/or platelets for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to pay for immunoglobulins or other similar treatments.]	This will be in or out. If in, [$2,500] the range will be $25 – $5,000
[Ambulance **We** will pay [$500] when [a **Covered Person** requires][**You** require] **Ambulance** transportation and [$5,000] when [that **Covered Person** requires][**You** require] air ambulance transportation to a **Hospital** for **Injuries** sustained in a **Covered Accident.** Air Ambulance services must take place within [forty-eight (48)] hours of the **Covered Accident**. **Ambulance** transportation must be within [forty-eight (48)] hours of the **Covered Accident**. A licensed professional ambulance company must provide the ambulance service. A licensed professional air ambulance company must provide the air ambulance service.]	This will be in or out. If in, [$500] the range will be $25 – $1,000 [$5,000] the range will be $25 – $10,000 [forty-eight (48)] the range will be 12 – 96 [forty-eight (48)] the range will be 12 – 96
[Transportation **We** will pay [$25] per round trip, up to three round trips per calendar year, [per **Covered Person**][to **You**] per round trip to a **Hospital** when [a **Covered Person**	This will be in or out. If in, [$25] the range will be $25 - $1,000

requires][**You** require] **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident**. This benefit may also be used; if a covered **Dependent Child** requires **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident,** if commercial travel is necessary and such **Dependent Child** is accompanied by a person **Related** to [the **Covered Person**][**You**]. This benefit is not for transportation to any **Hospital** located within a [fifty (50)]-mile radius from the site of the **Covered Accident** or [**Your**] residence [of the **Covered Person**]. The local attending **Physician** must prescribe the treatment requiring **Hospitalization** or **Hospital Confinement**, and the treatment must not be available locally. This benefit is not for transportation by ambulance or air ambulance to the **Hospital**.]	[fifty (50)] the range will be 5 - 100
[Accommodations During Hospital Confinement **We** will pay [$50] per night, limited to one motel/hotel room per night, up to [five (5)] days per **Covered Accident** for one motel/hotel room for a member of the immediate family who accompanies [a **Covered Person**][**You**] when admitted for **Hospitalization** or **Hospital Confinement** for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is paid only during the same period of time [the injured **Covered Person** is required to be] [that **Your** injury requires **You** to be] confined to the **Hospital**. The **Hospital** and motel/hotel must be more than [fifty (50)] miles from [the [**Covered Person's**][**Your**] residence.]	This will be in or out. If in, [$50] the range will be $25 – $1,000 [five (5)] the range will be 5 - 30 [fifty (50)] the range will be 5 – 100
For the purposes of this rider only, the following definitions apply:	
[**Ambulance** means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded. Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]	This will be in or out.
[**Durable Medical Equipment** means equipment or apparatus of a type that is designed primarily for use, and used primarily, to assist persons suffering from illnesses or injuries that restrict their normal mobility and function and includes equipments such as a wheelchair or a hospital bed. It does not include items commonly used by persons that are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health such as a stationary bicycle or a spa.]	This will be in or out.
Dislocation means a completely separated joint due to an **Injury**. The **Dislocation** must be diagnosed by a	

Physician [within seventy-two (72) hours] after the date of the **Injury** and require correction by a **Physician**. **Fracture** means a break in a bone due to an **Injury** and that can be seen by X-ray or other similar diagnostic exam. The **Fracture** must be diagnosed by a **Physician** [within fourteen (14) days after the date of the **Covered Injury**] and require correction by a **Physician**. This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.	[within seventy-two (72) hours] will be in or out. [within fourteen (14) days after the date of the **Covered Injury**] will be in or out. [not] will be in or out.

COMPLICATIONS OF PREGNANCY BENEFIT - U-IMC-178-A AR (09/11)

If [a **Covered Person** suffers][**You** suffer] **Covered Complications of Pregnancy**, [other than a **Non-elective Cesarean Section**,] resulting from a **Covered Accident**, **We** will pay the [coinsurance percentage of the] [**Usual and Customary**] expenses for **Medically Necessary** Covered Medical Service(s) incurred up to the Maximum Amount as shown in the Schedule. [The Maximum Amount is the amount payable per calendar year for all **Covered Complications of Pregnancy** payable under the **Policy**.] This benefit is payable only for such Covered Charges incurred [after the **Deductible**, as shown on the Schedule, has been met and] on or after the date [the **Covered Person** suffers][**You** suffer] the **Covered Complication(s)**. [**Complications of Pregnancy** Benefits are in excess of all other valid and collectible insurance.]	[other than a **Non-elective Cesarean Section**,] will be in or out. [coinsurance percentage of the] The coinsurance percentage will range from 5% - 50%. [**Usual and Customary**] will be in or out. This will be in or out. If in, The Maximum Amount will range from $100 to $100,000. This will be in or out. If in, the Deductible will range from $0 to $10,000. This will be in or out.
[If the **Covered Complication of Pregnancy** is a **Medically Necessary Non-elective Cesarean Section**, after the applicable **Deductible** has been met and on or after the date the **Non-elective Cesarean Section** is performed, benefits are payable on the same basis as any other **Covered Complication** for Covered Charges incurred, up to the Maximum Amount shown in the Benefit Schedule.]	This will be in or out. The Maximum Amount will range from $100 to $10,000.
[Additional Benefit If the [**Covered Person's**] [**Your**] coverage terminates solely due to the birth of a child, an Additional Benefit will be provided for [six (6)] [weeks][months] from the date of termination for [**Covered Complications**] [and] [post-partum depression] resulting solely from that **Covered Accident**. This benefit is payable only for such Covered Charges incurred [after the applicable **Deductible**, as shown on the Schedule, has been met and] on or after the date [the **Covered Person** suffers][**You** suffer] the **Covered Complication(s)**, subject to **the** Additional Benefit Maximum Amount shown on the Schedule. [The overall Maximum Amount for **Complications of Pregnancy** payable per calendar year will be reduced by the amount paid under this Additional Benefit.] Benefits provided under this rider are subject to all other terms and limitations of the **Policy**.]	This will be in or out. If in, [six (6)] the number of weeks or months will be inserted will range from 4 weeks to 6 months; [weeks] will be in or out [months] will be in or out. [**Covered Complications**] will be in or out. [and] will be in or out. [post-partum depression] will be in or out. This will be in or out. If in, The overall Maximum Amount will range from $100 - $10,000.
For the purposes of this rider only, the following additional definitions apply:	
Covered Complications of Pregnancy (Covered Complications) means any of the following conditions requiring [treatment by a **Physician**] [**Hospital Confinement**] [when the pregnancy is not terminated] whose diagnoses are distinct from but adversely affected by pregnancy or caused by pregnancy, including:	[treatment by a **Physician**] [**Hospital Confinement**] will be in or out. [when the pregnancy is not terminated] will be in or out.
5. similar medical and surgical conditions of comparable severity;[and] 6. [**Non-elective Cesarean Section**;] [and]	[and] will be in or out. [**Non-elective Cesarean Section**;] [and] will be in or out.

7. [spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.]	This will be in or out.
Covered Complications of Pregnancy do not include false labor, occasional spotting, [**Physician**-prescribed rest during the period of pregnancy,] morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.	This will be in or out.
[**Deductible** means the amount of **Usual and Customary Expenses** for **Medically Necessary** treatment of [**Covered Complications**][**Non-elective Cesarean Sections**] that must be incurred by [the **Covered Person**] [**You**] before [**Covered Complications**][**Non-elective Cesarean Section**] benefits become payable. The amount of the **Deductible** is shown in the Schedule. **Complications of Pregnancy** benefits are not payable for charges applied to the **Deductible**.]	This will be in or out. If in, [**Covered Complications**] [**Non-elective Cesarean Sections**] will be in or out. [**Covered Complications**] [**Non-elective Cesarean Sections**] will be in or out. the **Deductible** will range from $0 - $10,000.
Hospital Confined (**Hospital Confinement)** means admission to a **Hospital** as an inpatient [for at least twenty-four (24) consecutive hours] by a **Physician** for a **Covered Complication**.	This will be in or out.
[**Non-Elective Cesarean Section** means an unscheduled cesarean section due to an emergency which puts the life and health of [the **Covered Person**][**You**] or fetus in jeopardy.]	This will be in or out.
Pre-existing Condition means a condition for which a [**Covered Person**] [**You**]received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [six (6)] months immediately preceding the **Covered Complication(s)** [unless the condition for which the prescribed medication is taken remains controlled without any change in the required prescription].	[six (6)]. The range will be 1 to 18. This will be in or out.
[**Usual and Customary** Expense(s) (**Covered Charges**) means an amount(s) that: (1) is made for a **Covered Complication of Pregnancy**, (2) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and (3) does not include charges that would not have been made if no insurance existed [and (4) does not exceed the cost of a generic drug, if available. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available.]	This will be in or out. If in, This will be in or out. This will be in or out. If in, [seventy-five percent (75%)] The range will be 25% - 100%
For purposes of this rider only, Section VII Termination of	

Insurance is amended and replaced by the following:	
A. Policy Renewal and Termination. Renewal. This **Policy** is guaranteed renewable [until **You** reach age [seventy (70)]]. **We** cannot change any of the terms of this **Policy**, except that, in the future, **We** may increase the premium **You** pay.	This will be in or out. If in, [seventy (70)] the range will be 65 – 85.
This **Policy** and all insurance for **You** [and **Your Dependents**] will terminate on the earliest of the following:	[and **Your Dependents**] will be in or out.
2. On the date **You** reach age [seventy (70)];	[seventy (70)] the range will be 65 – 85.
B. [Termination of **Dependent's** Insurance.	This will be in or out. If in,
3. On the date the **Dependent** reaches age [seventy (70)];]	[seventy (70)] the range will be 65 – 85.
EXCLUSIONS: For the purposes of this rider only and in addition to the General Exclusions stated in Section IV of the **Policy**, **We** will not provide coverage for any of the following:	Any combination of exclusions 1 through 31 may be in or out.
[5. Personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals while confined in a **Hospital** [or for items taken away or home from the Hospital, [including but not limited to crutches, wheel chairs and walkers] [except **Durable Medical Equipment**]].]	This will be in or out. If in, This will be in or out. If in, [including but not…] will be in or out. [except…] will be in or out.
[11. Charges that are payable under automobile medical benefits [in excess of [$5,000]].]	This will be in or out. If in: [in excess…] will be in or out. If in, the range will be $500 - $10,000]
This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.	[not] will be in or out.

Zurich American Insurance Company

EXPLANATORY MEMORANDUM
Individual Accident Insurance Policy Riders
Company Filing Number – CW AH 34008
U-IMC-100-A (08/09), et al

Attached for your review are new forms for use with the Individual Accident Insurance product, previously approved by your Department.

The Individual Accident Policy and these riders may be marketed through brokers, consultants, third party administrators, financial institutions and sales employees.

These riders are new and are not intended to replace any other forms currently in use, with the exception of the Administrative Change Endorsement, form U-IMC-104-B which replaces the previously filed and approved "A" version of the form.

The Individual Accident Insurance product provides specified benefits for an accidental injury or death. Additional benefits are offered by way of riders. The forms are being filed concurrently in our domiciliary state of New York.

Variable data is bracketed. Amounts may vary and some provisions may be omitted depending upon the Individual's needs. Variable data will never exclude or limit provisions required by the jurisdiction in which the Policy is issued. A detailed explanation of all variable data is included.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. While every effort has been made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

The Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission.

This filing includes a certificate of readability and statement of variables, as well as an actuarial memorandum and rating rules.

Administrative Change Endorsement

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS ~~ENDORSEMENT~~ ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under ~~Your~~the Individual Accident Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

[This endorsement will be used to make the following types of administrative changes to the **Policy**~~, which are administrative in nature: (1) changes to the Schedule; (2) addition~~ at **Your** request:

1. Policyholder's Name or Address;
2. Addition or deletion of Covered ~~Dependents; and (3) other administrative changes to~~Dependent(s);
3. Addition or deletion of Coverage(s);
4. Increase or decrease in Coverage Amount(s);
5. Addition or deletion of Benefit Riders;
6. Increase or decrease in Benefit Amount(s); or
7. ~~1.~~ Renewal of the Policy.]

Except for the above, this endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy No. _____